A New Approach to Supporting Community Healthcare Funding

Testing and Guidance Document

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A New Approach to Supporting Community Healthcare Funding - Testing and Guidance Document

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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

1 Contents

1 Background

Since the introduction of a much more transparent approach to paying for acute health services through the use of consistent units of care known as currencies, it has been an ambition to develop currencies for community services. However, priorities in other areas and the difficulty of gathering consistent evidence to support this work has to date prevented the ambition being realised.

It is widely recognised that community services lie at the heart of the vision for delivering the Five Year Forward View and this theme continues in the Long Term Plan. However, there remains a significant lack of quality data available at the national level. The establishment of a national Community Services Data Set (CSDS) in November 2017 will help to correct this, but as with all new data sets it will take some time until all providers supply consistent and complete data.

With the new data set in place it is now the right time to give priority to developing community currencies to support the ambitions of the Five Year Forward View. It forms part of our work programme which has been signed off by the Chief Executive of NHS England.

The development of Community Healthcare Currencies will support delivery of the following objectives set out in the Five Year Forward View:

- **The Health and Wellbeing Gap**
  Promote wellness through preventative interventions and incentivise greater patient empowerment through self-management and engagement.

- **The Care and Quality Gap**
  Promote collaborative working across service boundaries by focusing on the needs of staff and patients to deliver the outcomes they need. We will use outcomes as part of the currency framework to measure the effectiveness of care from both a clinical and patient perspective. Where practical we will use outcome data as part of the currency framework and payment approach.

- **The Funding and Finance Gap**
  Using outcomes as part of the currency framework to measure the efficiency of care delivered against agreed process markers.

This project was commissioned by NHS England and supported by NHS Digital and NHS Improvement.

Community services are often defined by what they are not and although services in different organisations may share a name, they frequently have different professional definitions and modes of delivery across England. The development of community currencies presents an opportunity to focus on needs-based systems of service design, delivery and payment definitions. Five distinct patient groups were identified and defined through discussions with the clinical leadership in NHS England, and other stakeholders. Task and finish groups were established to think about an appropriate currency mode for each of these distinct populations of care need. The membership of the task and finish groups consisted of health and care professionals with specific expertise related to each specific population group. (See Annex A – Group Memberships.)

Each groups' primary objective was to form a currency model based on expert opinion which represents the needs of its area of focus, and which could be tested using the CSDS. The five population groups are:

- Children and Young People with disabilities
- Long Term Conditions
- Single Episodes of Care
- Frailty
- Last Year of Life

Having achieved their initial objective to develop a currency model for testing, the task and finish groups have been stood down temporarily and will be reconstituted to fit the next stage of the project; testing the currency models.

Pilot partners will be added to the membership. This will ensure the groups are focussed on testing the feasibility of the currencies and give pilot partners the opportunity to contribute to the overall vision, based on their practical experience, and to the further development of the currencies.

An Expert Reference Group has also been established to guide the overall project as well as the work of the task and finish groups, providing advice and recommendations against the triple aims of the Five Year Forward View. (See Annex B – Expert Reference Group - Terms of Reference.)

2 Introduction

This document sets out the process for testing the draft currencies developed as part of the Community Currency Development Project.

Specifically, this guidance:

- introduces and explains the concept of a currency and its purpose
- introduces the five currency models the project has developed and defines the boundaries between the models
- describes how it envisages the currencies will be used to understand the costs of delivering care to groups of similar patients
- outlines the aims and approach of the testing phase of the project including critical success factors
- describes the methods in which organisations can support the currency testing and set out the requirements for these organisations
- describes the support available for organisations testing the currencies and the benefits of being involved
- introduces the Community Services Data Set (CSDS), its purpose and provides links for further information

3 Quick Start Guide

As described in the Introduction, this document aims to give an in-depth narrative of the currency development work completed to date, describe each currency in detail, and explain the process that will be followed to test these currencies.

Across the country community services vary in many ways with care provided under different models in different settings. This was considered during the development phase, and a key objective of the work was to make sure the currencies interact with current processes, minimising additional administrative burden.

The community healthcare currencies will use the attributes of the Community Services Data Set (CSDS) to identify which person is a member of what currency population, and the complexity of their care needs. This will help establish the case mix, or groups of patients with similar needs, for each of the five currencies we are testing. CSDS is a nationally mandated dataset which means all organisations delivering community services funded from the public purse are required to make a monthly submission of activity data about their patients and the care delivered.

Nationally, providers are currently in the process of building data capture processes for the CSDS submissions into their daily work and monthly routines. This means each organisation will be in a different place on this journey and will therefore be starting at different points. We have therefore developed a flow chart which sets out the processes associated with testing the currencies, this will allow providers to understand the overall process, assess their current position, and proceed from the relevant point.

Review the five currency areas detailed in this document on pages 14-33

Decide which services provided by your organisation will be associated with each currency

Discuss with front line and information system colleagues which currencies could be feasibly tested

Complete the Pilot Provider Sign Up Questionnaire. If you require a copy, please contact england.communitycurrencies@nhs.net

If your organisation has not already signed up for the Community Services Data Set, registration will be required. See pages 35-36 for more information

Plan any necessary changes required to enable the collection, recording and submission of relevant data to the Community Services Data Set. General information can be found using the links on pages 35-37
Specific currency realted information can be found on pages 38-62

Attend a Pilot Provider Start Up Workshop
NHS England Pricing Team will be hosting a number of workshops tailored to Pilot Provider organisations. Please contact england.communitycurrencies@nhs.net for further information and to book a place

Submit data to the CSDS on a monthly basis. Further information can be found at the following links on page 36

Attend regular meetings which will provide updates on the progress on testing, enable key discussions regarding the models and give pilot provider organisations the chance to influence the development of currencies they are testing and how each currency works in relation to other community healthcare currencies

4 Introducing and using the currency

4.1 What is a currency?

A currency is a way of grouping patients' activities into units that are clinically similar and have broadly similar resource needs and costs. Each unit of currency must be evidence-based and analytically identifiable, but most importantly it must be clinically meaningful. The currency must be rooted to the care the patient receives and be practical to implement.

Currencies can take different forms, for example they can be based on a specific activity, or the time period over which a patient would be treated for a condition. One example of an activity based currency is an appendectomy carried out on an adult patient with a complications or comorbidities score of zero. The resources used to perform the procedure (staff, equipment, location and consumables such as dressings and drugs) are similar for different patients, so this type of appendectomy can be defined as a unit of currency. This will differ from other activity-based units of currency, such as, for example, a Coronary Artery Bypass Graft.

Another example from the acute sector is the currency model for patients with cystic fibrosis. Providers receive a year of care payment for each patient based on an annual clinical assessment which then anticipates their likely needs. The proposed currencies in this document are also based on the needs of the patient rather than on an individual procedure.

4.2 What a currency is not

Currency is often confused with tariff; however these two terms are not interchangeable. A currency refers to grouping healthcare into units of similar resource and clinical need, therefore cost. A tariff is a price assigned to a unit of currency or bundled package of care which may encompass a number of currency units. Tariffs can only be developed when there are recognisable and identifiable currencies in place. When a currency is consistently utilised by the sector, and robust information collected on the basis of the currency, then a price may be attached to it.

NHS England and NHS Improvement publish a set of national prices as part of the National Tariff Payment System (NTPS) Document. This also sets the rules for how prices are agreed locally between providers and commissioners for activity which does not have a national price.

For example, for the currency unit appendectomy carried out on an adult patient with a complications or comorbidities score of zero (HRG FZ20J). For 2018/19, the national price for this procedure is £1,868. This is the national price as detailed in the NTPS. The annual price for cystic fibrosis care ranges from £5,039 to £41,000 for 2018/19.

4.3 How and why are currencies used?

Currencies provide a consistent and transparent language for commissioners and providers to use when commissioning services. Whatever the local payment approach, that is used, currencies will support developing a shared understanding about how much funding will be needed to deliver any particular service.

The currencies we are testing will not have any prices associated with them at this stage. The aim of testing is to establish whether the draft currencies will work in practice in a variety of local care delivery models. This piloting approach is usually used when new currency models are developed so they can be refined as required and any unintended consequences identified.

As well as providing a basis for payment, currencies can result in a better understanding of the patient populations that providers serve and the costs incurred in treating them. They also allow benchmarking across providers, particularly when combined with the use of outcomes metrics.

For commissioners, the use of a currency model, and the resultant information can be used to ensure the service provided matches the needs of patients in a local health economy. It can support commissioners to drive quality and efficiency. Currencies can also inform service development and re-design, thus ensuring the money spent provides best value for patient populations and reimburses providers fairly for the work they do. They can also support the provision of personal health budgets for individual patients.

5 The approach to develop community currency models

At the outset, we realised to make rapid progress we would need to adopt a novel approach to currency design. Most currencies take a long time to develop because they rely on detailed analysis of large volumes of validated data at a national level. Gathering that data, in the absence of a national data set, takes 18 months to two years. As data has only just started to flow to the CSDS, to proceed at the desired pace we needed to find another methodology.

Community services have developed organically in each locality and therefore present a wide variety of models and service variations which do not lend themselves to the standardisation normally required to support national currencies. There is also no standard definition of what a community service is and it is often defined by what it is not, even this is increasingly challenged by new care models.

Given these factors our approach to developing currency models for community care has been based on these principles:

1. Defined populations of specific needs
2. Alignments to current transformation programmes across community services
3. Clinically validated care, cost and outcome models relevant to each population

We established an Expert Reference Group which would provide support at a strategic level and oversight to a number of task and finish groups. These groups were required to use the principles and develop a currency model for the population they were looking at.

The approach each task group took began with reviewing the following:

- Needs of the population
- Resource utilisation
- Clinical research around needs and care management and outcome measures
- Local patient level cost models

The review identified a number of possible approaches for currency design, which were discussed and assessed by the task groups, focusing on the most robust, practical and pragmatic options to formulate the baseline models which we now intend to test.

A fundamental assumption on which the currency models are based is that in general the unit of currency will be a year of care. The one notable variation to this is the Single Episode of Care Model. As the name implies, the unit of currency here will be the episode of care. The unit of currency dictates the basis on which we assess the case mix and associated resource used.

6 The currencies

6.1 Children and Young People with Disabilities

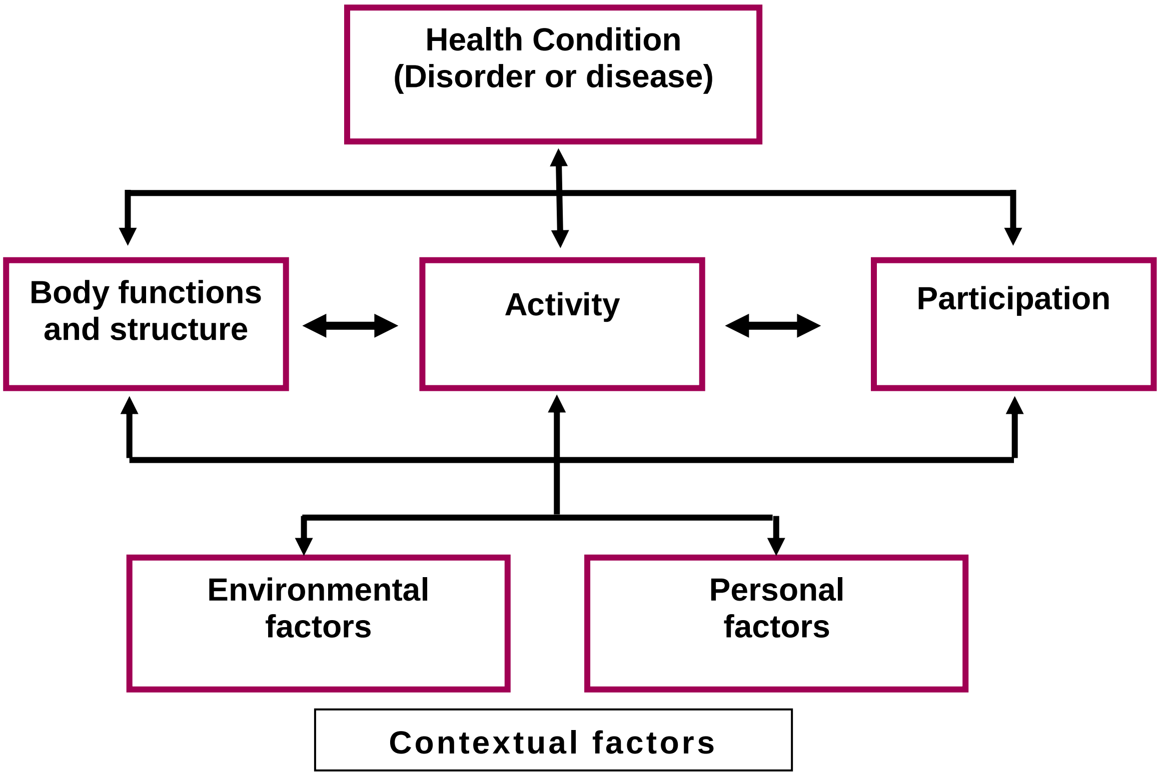
Introduction and Definitions

The World Health Organisation defines Disability as:

> “an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.”

This brings together the ‘medical model’ of disability, which considers health conditions, body structure and function, with the ‘social model’ of disability, which considers aspects of the wider environment that can be disabling, such as physical factors and peoples’ attitudes. Disability is something that can affect anyone at any time and can vary over time.

Using this definition of disability includes all children and young people with special educational needs and may be better understood as the interaction between different factors as shown in the diagram below:



Children and young people's disabling conditions may include:

- early developmental impairment
- cerebral palsies and other physically disabling conditions
- chromosomal and genetic conditions
- acquired brain injuries (after the acute phase of care)
- neurodevelopmental conditions such as autism spectrum
- attention deficit conditions
- learning disabilities
- vision and/or hearing impairments
- speech, language and communication needs
- emotional and behavioural needs (other than those requiring the specialist input of Child and Adolescent Mental Health Services)
- needs associated with their vulnerability or social circumstances.

Design Principles

In 2012, the former National Clinical Director for Children and Young People (Sheila Shribman) asked the question: "Why do we still not know who or where disabled children are in the UK in the 21st Century?" This led to a number of strands of work, one of which was The Academy of Medical Royal Colleges project to develop clinical terminologies to describe patient needs.

A terminology set was developed within SNOMED-CT[1] (See Community Services Data Set (CSDS)) that describes the health and care needs of all children and young people at headline level and disabled children and young people in more detail. This had input from a number of paediatricians, allied health professionals and parent/carers, and was supported by a specialist in terminology from the Department of Health and Social Care team. It was underpinned by the WHO ICF model of disability described above.

The terminology set was included in the Children and Young People's Health Services (CYPHS) data set, which has now transformed into the Community Services Data Set (CSDS). This dataset is collected and maintained by NHS Digital and all NHS providers of publicly funded children's community services are mandated to report data. This includes services commissioned by local authorities such as health visiting and school nursing.

The advantages of using SNOMED CT over and above other coding systems such as Read coding, ICD coding etc., are that it will be the coding system for the NHS of the future, SNOMED CT will be implemented across systems in all care settings by April 2020. SNOMED CT allows for coding of much more than health conditions or diagnoses, it also allows for coding of environmental factors, technologies, need for round the clock care etc.

The currency model is based on work that has been led by Dr Karen Horridge based at City Hospitals Sunderland NHS Foundation Trust and a member of the Executive Committee of the British Academy of Childhood Disabilities.

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[1] Systematized Nomenclature of Medicine Clinical Terminologies

This work was designed to expose variation in how the health needs of children and young people are described, and thus variation in how their health needs were being met, so that this could be addressed, to achieve the best possible outcomes for all children and young people.

It is built upon collecting data about the multi-faceted needs of patients at the point of care. This can sharpen clinical focus by:
- Acting as a prompt to troubleshoot for the range of needs that have previously been described in a given health condition;
- Driving early identification of needs and thus more timely interventions to meet them;
- Encouraging proactive, clinical management of identified needs and advocacy regarding environmental needs, rather than passive monitoring of the natural history of disabling conditions.

Dr Horridge and her colleagues have analysed 7,678 captured needs over 8,392 consultations in the Sunderland paediatric disability service, and more than 8,000 needs identified in c1,200 consultations in paediatric services across other areas in England. [2] [3]

This research led to the development of the Disabilities Complexity Scale. The scale combines:
    - underlying health conditions
    - family reported issues
    - technology dependencies
    - the need for round the clock care.

These form the four categories of need for the currency model. Data collected through the research has demonstrated a strong correlation between the number of needs and overall complexity and therefore cost of care.

As a result of this work 296 specific needs were identified and defined in the Explanatory Glossary of Paediatric Disability Terms which includes the SNOMED-CT codes for each term. The Glossary also includes suggestions for person-centred outcomes and actions required to achieve these.

The proposed currency model supports a model of care that is person-centred and family focused, encouraging self-management, supporting families to identify their needs, and to come up with their own ideas about how their needs may be met.

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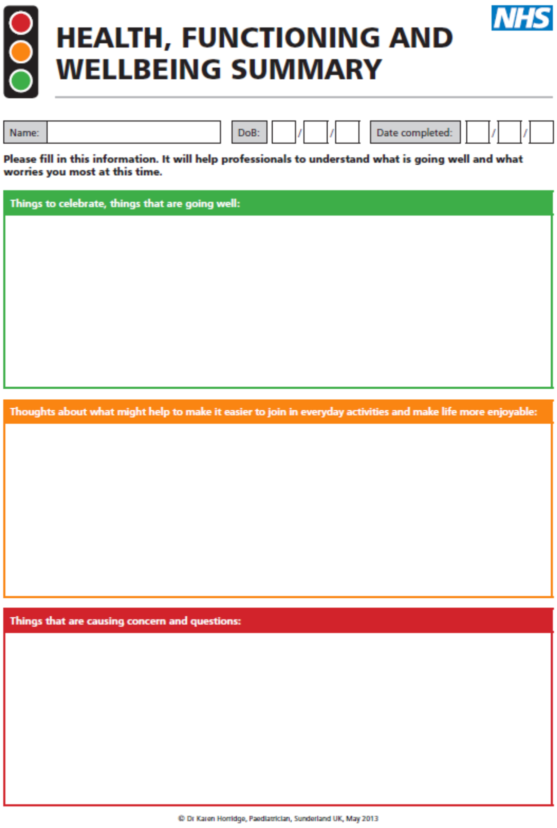
[2] Horridge KA, Harvey C, McGarry K, Williams J, Whitlingum G, Busk M, Fox S, Baird G, Spencer A. Quantifying multifaceted needs captured at the point of care. Development of a Disabilities Terminology Set and Disabilities Complexity Scale. *Dev Med Child Neurol.* 2016;58(6):570-580

[3] Horridge KA, McGarry K, Williams J, Whitlingum G. Prospective pilots of routine data capture by paediatricians in clinics and validation of the Disabilities Complexity Scale. *Dev Med Child Neurol.* 2016;58(6):581-588

The team, led by Dr Horridge, has developed a simple tool, using a traffic light approach, which is intended to be used by children and families before every consultation so that they can prioritise the issues that matter to them and bring their concerns to each consultation. Data collected from the traffic light tool can be used to monitor the effectiveness of care as concerns and priorities change over time.



HEALTH, FUNCTIONING AND WELLBEING SUMMARY

NHS

Name: DoB: / / Date completed: / /

Please fill in this information. It will help professionals to understand what is going well and what worries you most at this time.

Things to celebrate, things that are going well:

Thoughts about what might help to make it easier to join in everyday activities and make life more enjoyable:

Things that are causing concern and questions:

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Name: DoB: / / Date completed: / /

For each of the following areas please indicate which traffic light colour best matches your level of concern.

No Concerns	Does not limit joining in every day activities or enjoying life.
Some Concerns	Regularly but intermittently limits joining in every day activities or impacts on ability to enjoy life.
Serious Concerns	Frequently or daily limits joining in every day activities or impacts on ability to enjoy life.

	No Concerns	Some Concerns	Serious Concerns
General physical health	🟩	🟧	🟥
Airway & breathing issues	🟩	🟧	🟥
Recurrent chest infections	🟩	🟧	🟥
Pain	🟩	🟧	🟥
Seizures (fits, faints, funny turns)	🟩	🟧	🟥
Eating, drinking, swallowing issues	🟩	🟧	🟥
Drooling	🟩	🟧	🟥
Acid reflux (acidy, smelly burps), vomiting	🟩	🟧	🟥
Constipation (infrequent stools, hard to pass)	🟩	🟧	🟥
Soiling	🟩	🟧	🟥
Day time wetting	🟩	🟧	🟥
Night time wetting	🟩	🟧	🟥
Period issues	🟩	🟧	🟥
Ear, nose or throat issues	🟩	🟧	🟥
Skin issues	🟩	🟧	🟥
Faltering weight gain	🟩	🟧	🟥
Overweight issues	🟩	🟧	🟥
Mobility, moving around	🟩	🟧	🟥
Hand function	🟩	🟧	🟥
Personal care (self feeding, washing, dressing, toileting etc.)	🟩	🟧	🟥
Vision (eyesight)	🟩	🟧	🟥
Hearing	🟩	🟧	🟥
Speech, language, communication	🟩	🟧	🟥
Friendships and relationships, social communication	🟩	🟧	🟥
Disruptive behaviour	🟩	🟧	🟥
Emotional issues (mood, anxiety)	🟩	🟧	🟥
Self-injury	🟩	🟧	🟥
Sensory sensitivities (e.g. to sounds, textures etc.)	🟩	🟧	🟥
Pica (eats inappropriate things e.g. soil, metal etc.)	🟩	🟧	🟥
Learning	🟩	🟧	🟥
Sleep	🟩	🟧	🟥
Family issues	🟩	🟧	🟥
School issues	🟩	🟧	🟥
Equipment issues	🟩	🟧	🟥
Housing issues	🟩	🟧	🟥
Access to leisure activity issues	🟩	🟧	🟥
Are you well enough supported?	🟩	🟧	🟥
Do you have enough information about your child's condition and services?	🟩	🟧	🟥
Other (please specify):	🟩	🟧	🟥

© Dr Karen Horridge, Paediatrician, Sunderland UK, May 2013

The total number of specific needs reflect the level of complexity of each child. The four categories of need have different levels of resource requirement and hence associated costs. The template for the tool can be found here.

Work carried out thus far suggests the underlying health condition(s) and any family issues can have similar impacts on resource requirements. These increase with the addition of any technology dependencies, while a requirement for round-the-clock-care has the highest resource requirement of all.

Dr Karen Horridge's work confirmed these four categories of need. Looking at the categories of need along with the number of needs, this can be used to form a currency model that supports the active management of the identified needs of children and young people living with disabilities and life limiting conditions as follows:

Children and Young People Currency Model

Currency Units	Number of Needs	Disability Complexity Categories
CYP_01	1-4 Needs	C - F
CYP_02	5-10 Needs	C - F
CYP_03	5-10 Needs	C - F - T
CYP_04	5-10 Needs	C - F - R
CYP_05	5-10 Needs	C - F - T - R
CYP_06	11+Needs	C - F
CYP_07	11+Needs	C - F - T
CYP_08	11+Needs	C - F - R
CYP_09	11+Needs	C - F - T - R

Needs are defined in the Disabilities Terminology Set – SNOMED-CT Codes

C = Health Condition
F = Family Reported Issues
T = Technology dependencies
R = Round the clock care

6.1.1 Transition

We want the currency model to support services that are empowering children to actively engage in decisions about their care needs, including those that relate to a smooth transition to adult services. The currency recognises that additional resources may be required during transition with two specific currency units in addition to the nine other units.

CYP-T1	Transition-Preparation	to support development of a transition plan
CYP-T2	Transition-Implementation	to support implementation of the transition plan

The first covers pre-transition preparation that results in producing a comprehensive transition plan in which the child and family are fully engaged. The second covers the implementation of that plan with actual reported start date of the transition plan being the trigger.

To support this, the first update to the CSDS, v1.5, will enable the preparation and implementation of a transition plan to be captured.

6.1.2 Children with no underlying disability

We recognise that there is still a potential gap in our community health care model for children and young people. Universal services and the Children and Young People with Disabilities models do not cover the episodic needs of children and young people whose needs sit between these two. We are looking at suitable methodologies to support a model covering a variety of single episodes of care needs that may range from short speech and language courses to more complex treatment needs. As part of this work the Royal College of Paediatricians and Child Health are looking at a suitable terminology set that would potentially be the basis for any such model going forward.

Throughout the testing process we will look at any other potential gaps and will also assess the way in which the children and young people with disabilities model relates to existing currencies.

6.2 Long Term Conditions

Introduction and Definitions

A Long Term Condition is defined as a physical or mental health condition from which the person is unlikely to fully recover, and where the person is likely to require maintenance treatment and / or lifestyle adaptation to achieve the best quality of life possible for their circumstances.

Approximately 15 million people in England are living with one or more long term conditions. Long term conditions are more prevalent in older people (58% of people over 60 compared to 14% under 40). People in the poorest social class on average have 60% higher prevalence rates, and 30% more disease severity than those in the higher social classes[4].

Treatment and care for people with long term conditions is estimated to take up approximately £7 in every £10 of the total health and social care expenditure. Analysis of individual long term conditions suggests the numbers are growing, and the number of people with multiple long-term conditions also appears to be rising.[5]

Design Principles

In the absence of a body of nationally visible, validated and detailed data on long-term conditions and associated care activities carried out in the community, the task and finish group took the overarching design principles and developed them specifically to the needs of people with long term conditions; supporting better health outcomes and experiences, decreasing costs and increasing staff satisfaction. We used clinically validated concepts and tools to construct the currency model, a patient activation scale, and a needs and provision complexity scale.

Patient Activation

'Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and care, and is sometimes known as health literacy. Evidence shows when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions.

There are currently a number of scales being used to measure patient activation. For the purposes of the currency any activation tool can be used which uses, or can be converted to, a four point measure where 1-2 = low and 3-4 = high.

A lot of work has been done internationally to demonstrate and apply the concept of patient activation. Studies in England and internationally have shown that patient activation has a significant impact on resource utilisation and cost. One of the key findings is that compared to those patients with low level (1) engagement, high level

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[4] Department of Health and Social Care; Report; Long-term conditions compendium of information: 3rd Edition

[5] Department of Health and Social Care; Report; Long-term conditions compendium of information: 3rd Edition

(4) patients had 18% fewer GP appointments, and 38% fewer emergency admissions.[6]

Patient activation can be dynamic and can fluctuate with changes in a person's health status, increasing complexity of their condition, or the accumulation of new long term conditions. Health literacy may be taken as a broader measure to include those closely associated with and in the sphere of influence of the patient, to include family members and carers.

Patient activation encourages appropriate levels of interaction with health and social care professionals it is not a replacement for them.

Needs Provision and Complexity Scale (NPCS)

The Needs and Provision Complexity Scale looks at both patient's health and social care needs. It combines 16 separate scores which measures these needs to form an overall score. The development of the scale was led by Professor Lynne Turner-Stokes[7], Herbert Dunhill Chair of Rehabilitation, Kings College London.

The scale used by the currency goes from 1 to 50. It combines 16 metrics covering both health and social care needs to describe the complexity of care needs for a patient at a specific point in their care. The metrics are set out in the following diagram.

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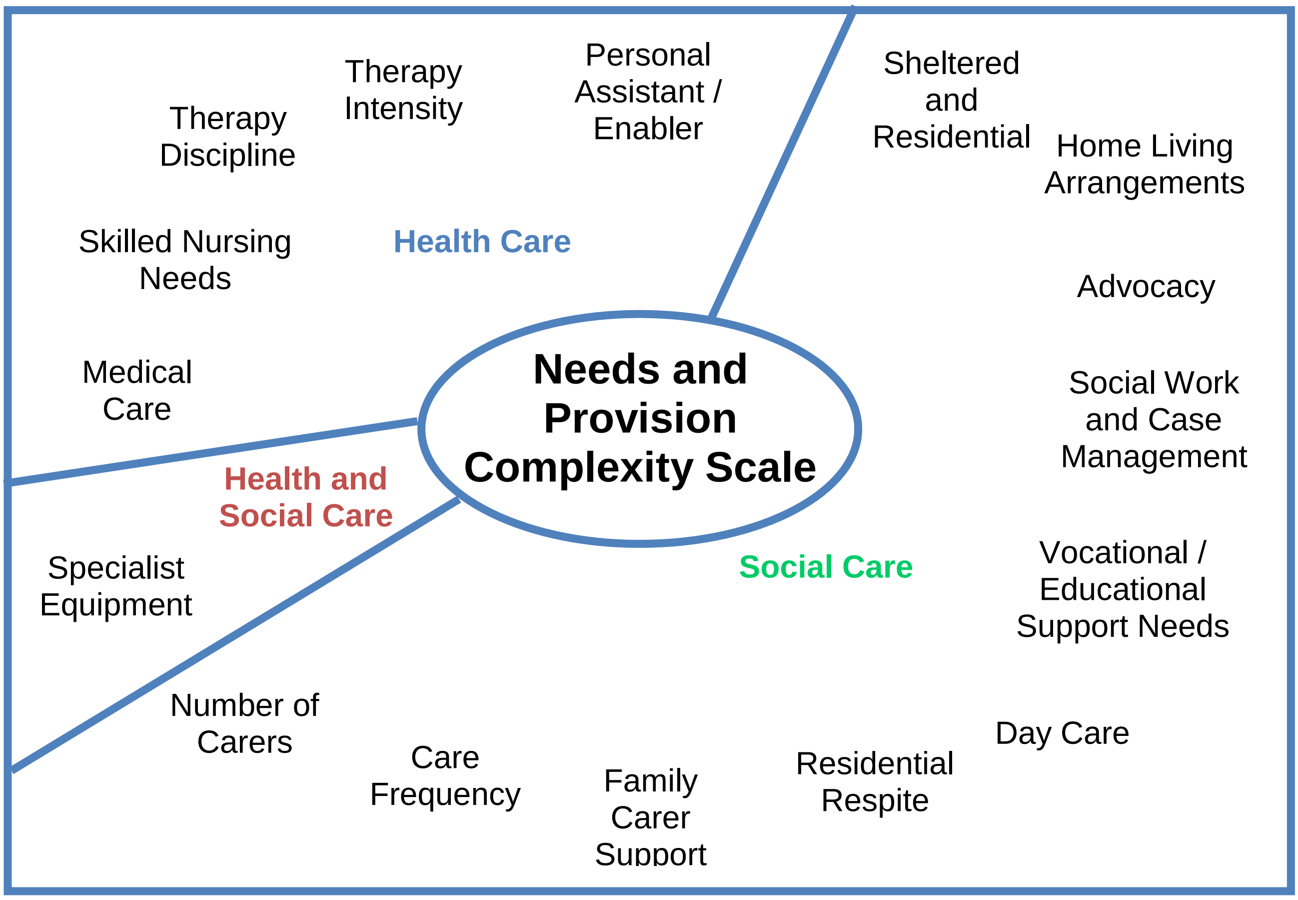
[6] Barker I., Steventon A., Williamson R., Deeny Sarah R. Self-management capability in patients with long-term conditions is associated with reduced healthcare utilisation across a whole health economy: cross-sectional analysis of electronic health records BMJ Quality and Safety (in press)

[7] Turner-Stokes L, Siegert RJ. *The Needs and Provision Complexity Scale: factor structure and repeatability.* Poster Presentation. 7th World Congress in Neurorehabilitation; 2012; Melbourne. Abstact published in *Neurorehabilitation and Neural Repair* 2012; 26(6): 695-804 (Poster 48)
Turner-Stokes L, Siegert RJ. *The Needs and Provision Complexity Scale: measuring met and unmet needs in the community for patients with complex neurological disabilities.* Poster Presentation. 7th World Congress in Neurorehabilitation; Melbourne. May 2012
Neurorehabilitation and Neural Repair 2012; 26(6): 695-804 (Poster 49)



Further information on the NPCS can be found here. An NPCS score sheet, including a worked example, can be viewed here.

Although NHS England's mandate does not include commissioning social care it is clear that unmet need in this area often increases health costs and complicates the delivery of healthcare. The scale provides a patient centred view of complexity of need. The currency will support a variety of payment mechanisms including Continuing Healthcare where all health and social care costs are met by the NHS. It will also support local arrangements where health and social care budgets have already been combined.

Long Term Conditions Currency Model

The model combines information from using a Patient Activation tool and the NPCS to form twenty currency units.

NPCS defines for each person the total complexity of their care need and the relationship between complexity and healthcare resource and therefore cost is well established. The task and finish group felt that NPCS alone did not account for the variation that occurs in the care of people with long term conditions. It was felt that the vital element missing was a person’s health literacy and competency in self-management and engagement with healthcare systems. This is generally referred to as patient activation and acts as a modifier on complexity resulting from informed and appropriate behaviours.

Currency Unit	Patient Activation	Needs and Provision Complexity Scale	
		Lower value of range	Higher value of range
LTC_01	Low	1	5
LTC_02	Low	6	10
LTC_03	Low	11	15
LTC_04	Low	16	20
LTC_05	Low	21	25
LTC_06	Low	26	30
LTC_07	Low	31	35
LTC_08	Low	36	40
LTC_09	Low	41	45
LTC_10	Low	46	50
LTC_11	High	1	5
LTC_12	High	6	10
LTC_13	High	11	15
LTC_14	High	16	20
LTC_15	High	21	25
LTC_16	High	26	30
LTC_17	High	31	35
LTC_18	High	36	40
LTC_19	High	41	45
LTC_20	High	46	50

6.3 Single Episodes of Care (SEoC)

Introductions and Definitions

People require healthcare for a wide range of medical problems, often unrelated to any long term conditions that they may also have. Examples include a short course of physiotherapy or re-ablement. Or it could be for a longer period to support a complex recovery programme following a significant accident or major surgery.

What these episodes of care have in common is a defined start and end date, and the expectation that the person will recover, or stabilise and return to life as normal for them.

Design Principles

In the absence of a body of nationally visible, validated and detailed data on single episodes of care and associated care activities carried out in the community, the task and finish group took the overarching design principles and developed them specifically to meet the needs of people requiring single episodes of care.

Management of single episodes of care are in many ways similar to long term conditions management but differ in that a patient has a definitive start/end date to their programme of care and it is expected that the patient will return to the health that is normal for them. Due to the level of similarity the task and finish group felt that the principles applied to the LTC currency model would be applicable for SEoC and have opted to use the same baseline level for testing.

Patient Activation

'Patient Activation' describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions.

A lot of work has been done internationally to demonstrate and apply the concept of patient activation and studies in England and internationally have shown that patient activation has a significant impact on resource utilisation and cost. One of the key findings is that compared to PAM level 1, PAM level 4 patients had 18% fewer GP appointments, and 38% fewer emergency admissions.[8]

A range of different tools are available that categorise people living with long term conditions into high and low activation categories based on their level of engagement with a medicalised model of care and significant level of health literacy about their conditions (high activation); or a social model of care with less health care literacy (low activation).

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[8] Barker I., Steventon A., Williamson R., Deeny Sarah R. Self-management capability in patients with long-term conditions is associated with reduced healthcare utilisation across a whole health economy: cross-sectional analysis of electronic health records BMJ Quality and Safety (in press)

The measure is dynamic in that it will fluctuate with changes in a person's health status, increasing complexity of their condition or the accumulation of new long term conditions. Health literacy may be taken as a broader measure to include those closely associated with and in the sphere of influence of the patient, to include family members and carers.

Patient activation encourages appropriate levels of interaction with health and social care professionals, it is not a replacement for them.

There are currently a number of scales being used to measure the patient activation concept. For the purposes of the currency, any activation tool which uses or can be converted to a four point measure where 1-2 = low and 3-4 = high can be used.

Needs Provision and Complexity Scale (NPCS)

The Needs and Provision Complexity Scale combines 16 separate scores which measures a patient's health and social care needs to form an overall score. The development of the scale was led by Professor Lynne Turner-Stokes[9], Herbert Dunhill Chair of Rehabilitation, Kings College London.

The scale as used by the currency runs from 1 to 50, combining the 16 measures covering health and social care needs to define the complexity of care needs for a patient at a specific point in their care as shown in the following diagram.

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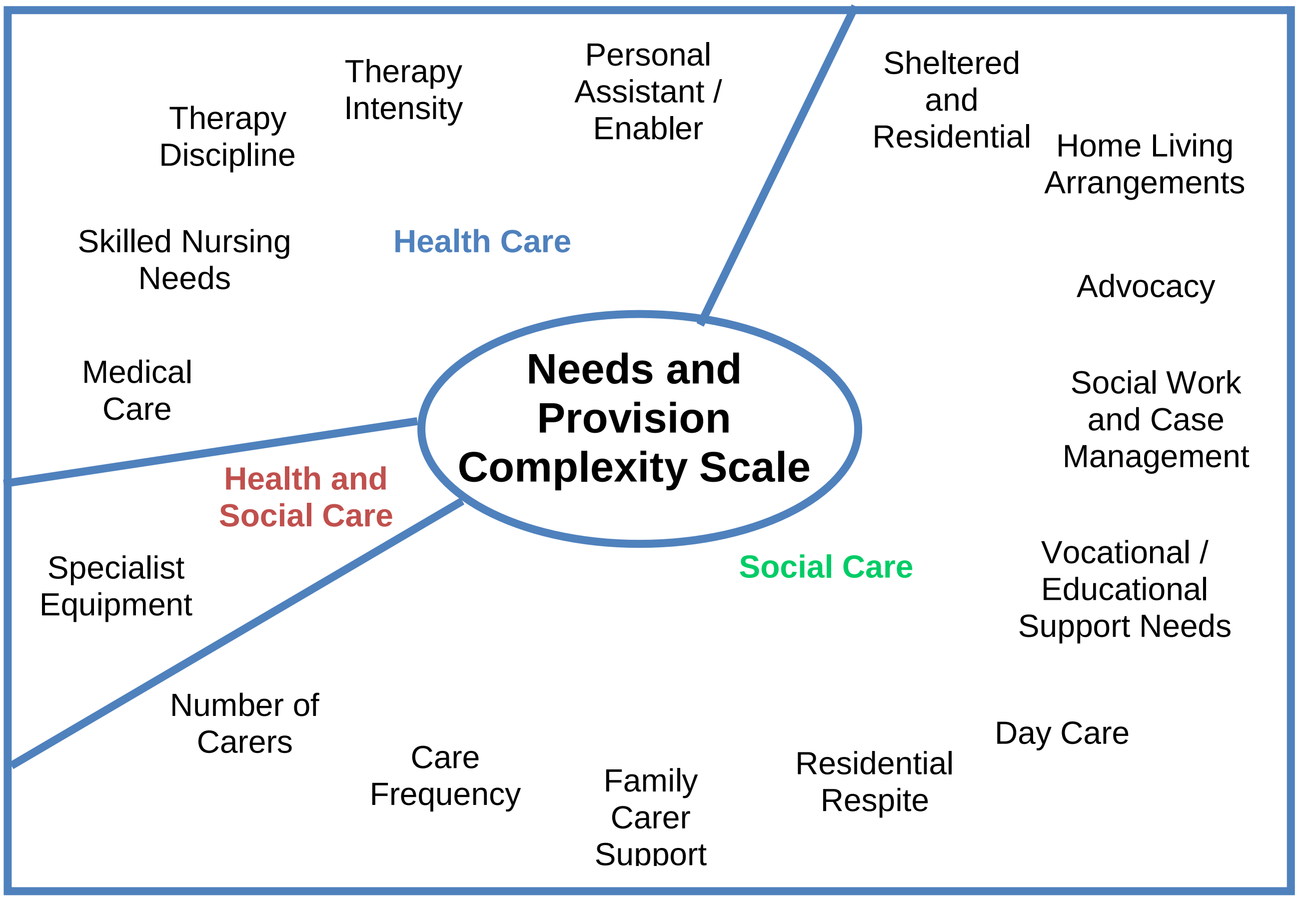
[9] Turner-Stokes L, Siegert RJ. *The Needs and Provision Complexity Scale: factor structure and repeatability.* Poster Presentation. 7th World Congress in Neurorehabilitation; 2012; Melbourne. Abstact published in *Neurorehabilitation and Neural Repair* 2012; 26(6): 695-804 (Poster 48)
Turner-Stokes L, Siegert RJ. *The Needs and Provision Complexity Scale: measuring met and unmet needs in the community for patients with complex neurological disabilities.* Poster Presentation. 7th World Congress in Neurorehabilitation; Melbourne. May 2012
Neurorehabilitation and Neural Repair 2012; 26(6): 695-804 (Poster 49)



Further information on the NPCS can be found here. The NPCS score sheet including a worked example can be viewed here.

Although NHS England’s mandate does not cover commissioning of social care, the impact of unmet need in this area often increases costs and complicates the delivery of healthcare. The scale provides a patient centred view of complexity of need. The currency will support a variety of payment mechanisms including Continuing Healthcare where all health and social care costs are met by the NHS; it will also support local arrangements where health and social care budgets have been combined.

Single Episodes of Care Currency Model

NPCS defines for each person the total complexity of their care need and the relationship between complexity and healthcare resource and therefore cost is well established. The task and finish group felt that NPCS alone did not account for the variation that occurs in the care of people with long term conditions. It was felt that the vital element missing was a person's health literacy and competency in self-management and engagement with healthcare systems. This is generally referred to as patient activation and acts as a modifier on complexity resulting from informed and appropriate behaviours.

Currency Unit	Patient Activation	Needs and Provision Complexity Scale	
		Lower value of range	Higher value of range
SEOC_01	Low	1	5
SEOC_02	Low	6	10
SEOC_03	Low	11	15
SEOC_04	Low	16	20
SEOC_05	Low	21	25
SEOC_06	Low	26	30
SEOC_07	Low	31	35
SEOC_08	Low	36	40
SEOC_09	Low	41	45
SEOC_10	Low	46	50
SEOC_11	High	1	5
SEOC_12	High	6	10
SEOC_13	High	11	15
SEOC_14	High	16	20
SEOC_15	High	21	25
SEOC_16	High	26	30
SEOC_17	High	31	35
SEOC_18	High	36	40
SEOC_19	High	41	45
SEOC_20	High	46	50

The SEOC and LTC currencies are currently identical; testing the currencies will help us to understand whether this is appropriate, and if not where the differences occur.

6.4 Frailty

Introduction and Definitions

Based on ONS 2016 figures, of the 55.3 million people living in England 18% are 65 or older, and about 50% of those 65 or older living with some level of frailty. This equates to about 4.9 million people.

NHS England defines frailty as “a long-term health condition characterised by loss of physical, emotional and cognitive resilience as a result of the accumulation of multiple health deficits. Frailty is progressive, typically erodes functional, cognitive and/or emotional reserves and increases vulnerability to sudden loss of independence and adverse health outcomes following a comparatively minor stressor event such as an acute infection or injury. While severe frailty can be comparatively easy to recognise and diagnose, lesser degrees of frailty may be more difficult to differentiate from normal ageing.”[10]

People may be frail but have no other long term heath conditions. As with other long term conditions, frailty can be effectively managed within primary care. There is often a trajectory of slow functional deterioration., Current evidence suggests a 3% accumulation of health deficits each year. However, through effective intervention, this accumulation can be reduced, with the potential to release resources for other health services.

Design Principles

In designing the currency model for frailty, the task and finish group decided to make use of a tool which is in use by general practices, called the Electronic Frailty Index, (eFI). Based on the NHS England definition of frailty this tool segments the population aged 65 or older into the following groups:

Not frail	50%	of population aged 65 or older in England
Mild frailty	35%	of population aged 65 or older in England
Moderate frailty	12%	of population aged 65 or older in England
Severe frailty	3%	of population aged 65 or older in England

The Toolkit for General Practice in supporting older people living with frailty advises that practices should stratify their population aged 65 and over by degree of frailty into those who are fit (not frail) and those who are living with mild, moderate or severe frailty using the Electronic Frailty Index. It should be noted that a diagnosis of frailty requires clinical judgement and cannot be assumed based on the eFI or any other scoring mechanism alone.

The eFI is a screening tool to identify those patients who are frail, a clinician from the primary care team should verify the frailty diagnosis. The currency model is based on this frailty diagnosis which has been combined with periodic assessment using the Clinical Frailty Scale (CFS) or similar validated tool.

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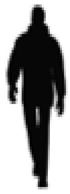
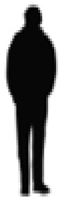
[10] NHS England: Toolkit for general practice in supporting older people living with frailty

The CFS is a 9 point scale which measures a person’s frailty from 1 – very fit to 9 – terminally ill. The diagram below defines each point in the scale.

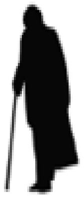
1 Very Fit - People who are robust, active, energetic and motivated. these people commonly exercise regularly. They are among the firttest for their age.



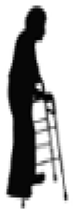
2 Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionall, e.g. seasonally.



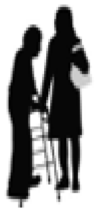
3 Managing Well - People whose medicak problems are well controlled, but are not regularly active beyond routine walking.



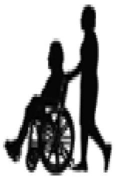
4 Vulnerable - While not dependant on others for daily help, often symptons limit activities. A common complaint is being "slowed up", and/or being tired during the day.



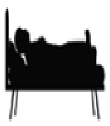
5 Midly Frail - These people often have more evident slowing, and need help in high order IADLS (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preperation and housework.



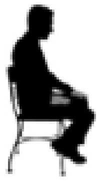
6 Moderatley Frail - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help bathing and might need minimal assistance (cuing, standby) with dressing).



7 Severley Frail- Completely dependant for personal care, from whatever cause (Physical or cognitive). Even so, they seem stable and not at high risk of dying (within - 6 months)



8 Very Severely Frail - Completely dependant, approaching the end of lilfe. Typically, they could not recover even from a minor illness.



9 Terminally Ill- Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia
The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

eFI scores broadly fit into CFS scores as shown in the table below.

	eFI Scores	CFS Scores
Mild Frailty	0.13-0.24	4 – Vulnerable 5 – Mildly Frail
Moderate Frailty	0.25-0.36	6 – Moderately Frail
Severe Frailty	>0.36	7 – Severe 8 – Very Severe 9 – Terminally Ill

The currency model is based three levels of frailty; mild, moderate and severe. This is further stratified by the progress of a person's frailty. For mild and moderate frailty this can be recoverable, stable and progressive. For severe frailty we recognise that this condition is unlikely to be recoverable but that the expected trajectory for individuals living with severe frailty is not yet fully understood. People living with severe frailty may therefore be considered stable, progressive or terminally ill. The latter we have termed 'end stage frailty'.

As part of the testing process we will be assessing severe frailty as the crossover or entry point to the Last Year of Life currency.

Frailty Currency Model

Currency Units	Severity	
FR_01	Mild – Recoverable	(CFS = 5 at T zero and <5 at time T)
FR_02	Mild – Stable	(annual accumulation of deficits ≤ 3%) (CFS = 5 at T zero and time T)
FR_03	Mild – Progressive	(annual accumulation of deficits > 3%) (CFS = 5 at T zero and >5 at time T)
FR_04	Moderate – Recoverable	(CFS=6 at T zero and <6 at time T)
FR_05	Moderate – Stable	(annual accumulation of deficits ≤ 3%) (CFS=6 at T zero and at time T)
FR_06	Moderate – Progressive	(annual accumulation of deficits > 3%) (CFS=6 at T zero and >6 at time T)
FR_07	Severe – Stable	(annual accumulation of deficits ≤ 3%) (CFS=7+ at time zero and at time T)
FR_08	Severe – Progressive	(annual accumulation of deficits > 3%) (CFS=7+ at time zero and 8 at time T)
FR_09	Severe – End Stage Frailty	(CFS=7+ at time zero and 9 at time T)

T Zero = at start

T = time scale for assessment to be agreed locally

6.5 Last Year of Life Currency (LYoL)

Definitions

The Last Year of Life Currency population is defined as those people identified as in the last year of life and therefore receiving End of Life Care. The currency targets 500,000 people who die each year in England. Not all deaths are expected, and around 120,000 deaths are supported by specialist palliative care. This is already supported by a currency specific to the complex needs of this group and is therefore excluded from the Last Year of Life currency. There is an expectation that each person will have a personalised care plan and be entered on a supportive and palliative care register by their GP.

People whose care would be covered by this currency may have a specific underlying condition, including but not limited to the following:

- malignant cancers
- heart failure
- chronic heart disease
- cerebrovascular disease (including stroke)
- renal failure
- chronic liver disease
- chronic obstructive pulmonary disease
- other chronic respiratory diseases
- neurodegenerative diseases
- Parkinson’s Disease
- Huntington’s disease
- multiple sclerosis
- multisystem degenerative conditions
- progressive supranuclear palsy
- Alzheimer’s dementia
- vascular dementia
- other unspecified dementia.

Design Principles

The currency model builds on the work of the specialist palliative care pilot 2012-2015 begun by the Department of Health and completed, following its formation, by NHS England. The pilot was supported by a detailed national data collection and extensive case mix analysis that gave rise to the specialist palliative care currencies for adults and children.

The LYoL community model applies an internationally proven Phase of Illness model, combined with a functional status model. The phase of illness model consists of five phases; Stable, Unstable, Deteriorating, Dying and Deceased. The following table defines the attributes of each stage, reflecting not only the patient’s needs but the circumstances of their environment.

Phase	Start of phase	End of phase
Stable	Patient problems and symptoms are adequately controlled by established plan of care and • Further interventions planned to maintain symptom control and quality of life **and** • Family/carer situation is relatively stable and no new issues are apparent	The needs of the patient and or family/carer increase, requiring changes to the existing care plan (i.e. the patient is now unstable, deteriorating or terminal)
Unstable	An urgent change in the plan of care or emergency treatment is required **<u>because</u>** • Patient experiences a new problem that was not anticipated in the existing plan of care, **and/or** • Patient experiences a rapid increase in the severity of a current problem; **and/or** • Family/ carers' experience changes which impact on patient care	• The new care plan is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. the patient is now stable or deteriorating) **and/or** • Death is likely within days (i.e. patient is now terminal)
Deteriorating	The care plan is addressing anticipated needs but requires periodic review **<u>because</u>** • Patient's overall function is declining **and** • Patient experiences an anticipated and gradual worsening of existing problem **and/or** • Patient experiences a new but anticipated problem **and/or** • Family/carers experience gradual worsening distress that is anticipated but impacts on the patient care	• Patient condition plateaus (i.e. patient is now stable) **or** • An urgent change in the care plan or emergency treatment is required **and/or** • Family/ carers experience a sudden change in their situation that impacts on patient care, and requires urgent intervention (i.e. patient is now unstable) **or** • Death is likely within days (i.e. patient is now terminal)
Dying	Death is likely within days	• Patient dies **or** • Patient condition changes and death is no longer likely within days (i.e. patient is now stable, or deteriorating)
Deceased	Patient has died; bereavement care provided to family/carer is documented in the deceased patient's clinical record.	Case closed.

The specialist palliative care pilot determined that the second most significant indicator for this population is their functional status, based on the Australian modified Karnofsky performance scale (AKPS) set out in the table below. AKPS functional status is expressed by three broad categories of high, medium and low.

	Status Score	Descriptor
High	100%	Normal no complaints; no evidence of disease.
	90%	Able to carry on normal activity; minor signs or symptoms of disease.
	80%	Normal activity with effort; some signs or symptoms of disease.
Medium	70%	Cares for self; unable to carry on normal activity or to do active work.
	60%	Requires occasional assistance, but is able to care for most personal needs.
	50%	Requires considerable assistance and frequent medical care.
Low	40%	In bed more than 50% of the time.
	30%	Almost completely bedfast
	20%	Totally bedfast and requiring extensive nursing care by professionals and/or family
	10%	Comatose or barely arousable
	0%	Dead

Last Year of Life Currency Model

The combination of phase of illness, and functional status gives the following currency model for people identified as in the last year of life:

Currency Unit	Phase of illness	AKPS Functional Status
LYOL_01	Stable	Low
LYOL_02	Stable	Medium
LYOL_03	Stable	High
LYOL_04	Unstable	Low
LYOL_05	Unstable	Medium
LYOL_06	Unstable	High
LYOL_07	Deteriorating	Low
LYOL_08	Deteriorating	Medium
LYOL_09	Deteriorating	High
LYOL_10	Dying	
LYOL_11	Deceased	

Other measures

The Integrated Palliative Outcome Scale (IPOS) is another tool in use which further enhances commissioning for value and outcomes. It is not included in this version of the currency should be collected routinely for future consideration. This is likely to be particularly relevant to any future outcome based commissioning intentions as IPOS is a tool which reflects both patient and clinical experience and expectations.

Evidence also suggests that Palliative Care Problem Severity Scores (PCPSS) available within SNOMED-CT may in the future further enhance this currency. We are presently waiting for the clinical validation of thresholds that would make possible the inclusion of the score in the currency model. We will however, be encouraging all those testing the currency to also record PCPSS so that we are able to revisit this at a later date.

7 Aim

The aim is to validate the currencies to ensure that they fulfil the following international best practice criteria –

1. Developing a currency for care
   The currency should -
   - be usable in normal working practices by front line health and care professionals, including those providers not currently collecting CSDS dataset information
   - support integrated care
   - support integrated multi-disciplinary team working and comparison with peers using standardised language
   - be clinically relevant and easy to use in practice
   - add value to front line health and care professionals on a day-to-day basis
   - be able to identify and support the improvement of outcomes
   - support the reduction of non-elective hospital admissions

2. Developing a currency for commissioning
   The currency should -
   - be compatible with current and future payment systems
   - be capable of supporting a wide range of payment approaches such as personal health budgets, capitated and population-based budgets and activity-based payments
   - be able to identify and support the improvement of outcomes
   - be driven by the needs of a patient, linking to wellness and reducing non-elective hospital admissions
   - incentivise the collection of high quality activity, cost and outcome data
   - facilitate benchmarking between providers
   - be compatible with future models of care
   - demonstrate support for proactive interventions and self-management

3. Simple to use
   The currency should –
   - use standardised language enabling comparison with peers
   - utilise data available, supporting the collect once, use many times principle
   - not increase the administrative burden to health and care systems by utilising available data and supporting the collect once, use many times principle
   - work within an integrated multi-disciplinary team
   - work in the current environment of varying IT maturity

4. Analytically robust
   The currency should –
   - show clear distinction between units
   - be easily definable and comparable
   - costs of each unit within a currency should be sufficiently homogenous

8 Testing Approach

Currencies have usually been developed by collecting large amounts of data for extended periods of time, with extensive iterative analysis undertaken to find significant drivers of cost.

To reduce the timescales in delivering community currencies an alternative approach was required. Designing currency models based on clinically validated research and tools has given clarity to how and what should be tested to arrive at a practical set of community healthcare currencies.

We were also aware that the Community Services Data Set (CSDS) would be available in the lifetime of the project, therefore timescales were aligned with the emerging maturity of the data set. All providers of publicly funded community services are mandated under the CSDS Data Provision Notice to provide monthly submission to the data set which will minimise any additional reporting burden for the purpose of this project. Using the CSDS also avoids the process of setting up a temporary collection solution which would be discontinued after testing and enables the recording of the journey towards the submission of data which can be used as part of the development of operational case studies.

8.1 Community Services Data Set (CSDS)

In October 2017, the CSDS superseded the Children and Young People's Health Services Data Set, expanding the scope of the data set to include adult care.

The Community Services Data Set is a patient level, output based, secondary uses data set which when fully operational across the sector will deliver robust, consistent information about the care delivered to people who use publicly-funded Community Services. As a secondary uses data set, it intends to re-use clinical and operational data for purposes other than direct patient care. It defines the data items, definitions and associated value sets to be extracted or derived from local systems.

The coding system of choice for CSDS is SNOMED-CT (Systematized Nomenclature of Medicine Clinical Terminologies), a structured clinical vocabulary for use in an electronic health record. SNOMED CT is a replacement for Read codes and was approved by Standardisation Committee for Care Information (SCCI) now known as the Data Coordination Board (DCB). Further documentation can be found here. It is a structured clinical vocabulary which includes diagnoses, procedures, symptoms, family history, allergies, assessment tools, observations, devices etc.

There are plans in motion to enhance the Community Services Data Set through a Phase II project as well as business as usual review and revision. The first business as usual update will take place in 2018/19 along with Phase II project scoping.

Providers of publicly funded community services funded by the NHS are legally required to collect and submit community health data. These requirements are set out by the Data Provision Notification and in the system suppliers' Information

Standard Notice. Therefore, using the CSDS as the collection tool will minimise the burden of collecting the data, ensuring we collect only once to use multiple times.

To test the currency effectively we want to ensure that, as well as engaging with a range of types of provider, we work with organisations at a differing range of digital maturity. This will enable us to understand the journey that providers make in order to provide high quality, useful data.

Further information can be found by clicking the links below

CSDS – NHS Digital
CSDS Data Model – NHS Digital
CSDS Technical Guidance – NHS Digital
CSDS Technical Output Specification – NHS Digital
CSDS User Guidance – NHS Digital
CSDS Data Provision Notice
CSDS Information Standard Notice
NHS Digital CSDS Direction

Submission dates for the CSDS can be found here

8.2 Developing case studies

Whilst the data is important in validating the currency, we will also need to collect other information. This will feed into our evaluation process. We will ask pilot partners to participate in one-to-one interviews, discussions and group workshops. This will help us to identify issues and will be logged as part of the process of recording the validity of the currency models we have developed.

We will also need front line clinical colleagues to complete short surveys to gauge the practicality of the requirements on them with regards to data collection.

Discussions, interviews, surveys and workshops will be informed by quantitative analysis of data and discussions with other providers, and we will use the information to develop case studies.

8.3 Patient Level Costing and Information Standards (PLICS)

Information supporting the case mix of each currency model is collected through the Community Services Data Set and the details of how this is achieved are set out in this guidance document.

It is expected that as Patient Level Costing and Information Standards (PLICS) for Community Services is established we will be able to use this data set to support the costing of the case mix. At the time of testing PLICS for Community Services is at road map testing stage and not available to fully support the costing exercise needed to prove the currency models. On current projections PLICS as a mandated cost collection will not be available until 2021/22. It is likely therefore that we will require a revision of reference cost collections for community services in order to support the currency models in the period following testing and leading up to the mandatory implementation of PLICS for Community Services.

There is an immediate need as part of the testing process to collect costs against case mix in order to complete the currency models. The currency models are each based on clinically validated models of the complexity of care and are reflective of the intensity of care needs. Integral to their structure the key resource in meeting care needs are health and care professionals, estimated to be approximately 80% of total resource costs.

The National Casemix Office proposes to collect resource costs in two ways. From the activity data collected by CSDS we will have a comprehensive record of health and care professionals actively delivering care by type and band directly associated with the case mix of each currency. Using agenda for change pay scale we will be able to account for 80% of costs associated with each of the currency models. The National Casemix Office will work directly with the pilot partners several of whom have patient level costing systems in place that are well established. We have also sought to recruit organisations working with PLICS including roadmap partners. In this way we expect to be able to establish a comprehensive costing structure for each of currency models as testing progresses.

Case mix data will be collected through CSDS monthly. The National Casemix Team (NCT) will work with pilot partners to establish the level of data quality and completeness required to begin detailed analysis this process is expected to take six months.

Once we have achieved a consistent level of quality the NCT will continue to review and analyse data submitted cumulatively. The expectation is that it may take from 9 to 12 months of data to prove stable trends in case mix.

Alongside this process the NCT will work with pilot partners on the associated costing envelopes that together will provide the final format of each currency model.

8.4 Future Pricing Policy Assumptions

Most of community services are currently funded by block contracts the aim of these currencies is to provide the evidence to support pricing based on a person-centred approach to active and pro-active care management. The way we will test the currency models is in part defined by underlying assumptions about future pricing policy. Four of the five currency models suggest a year of care approach where the core structure is based on complexity of care defined by the currency. This would be supported by clinical outcome metrics that may be applied at either an individual level for personal health budgets and continuing healthcare or at a care group – population level as appropriate for provider models of service delivery contracts and commissioning budgets. Single episodes of care because of their nature suggest episodic prices with the application of complexity and outcome metrics similar to the year of care models.

9 Testing

There are three aspects to the data collection process that must be met to take part in this project

- the minimum requirements in order to submit to the CSDS
- currency specific data items to be recorded
- activity/resourcing information.

9.1 Minimum data set submission requirements

The Testing section of this document will set out information on the data items which will be used for the purpose of testing the community currencies. This information should be used in conjunction with the following files which cover the broader CSDS and its requirements.

1. CSDS User Guidance – specifies information about the structure and content of the data set to be used by care providers and system suppliers.
2. CSDS Technical Guidance – details the data submission process and opportunities for submission
3. CSDS Technical Output Specification – provides a full definition of each item within the data set.
4. CSDS Data Model – a visual representation of the various tables within the data set and how the tables interact with each other.

The CSDS contains a large number of tables as shown in the documents above, the majority of these tables only need to be completed when a relevant contact, referral or activity occurs. There are three tables which must be completed for any submission to be accepted.

All submitted data require the following tables to be completed for all records:

- CYP001 Master Patient Index
- CYP002 GP Practice Registration

CYP101 Service or Team Referral is also required to be submitted at least once as part of each submission file.

Further information on the mandatory tables can be found in the CSDS User guide on p13.

9.2 Currency Specific Information

For each currency we have set out tables for which data needs to be captured and submitted in addition to the three tables listed above. The data items in these tables will enable the NHS Digital National Casemix Office to allocate activity to the specific currencies when analysing the data. Although the fields described below are not all required to provide a minimum submission, these data items should be considered as mandatory for organisations participating in testing the currencies.

For some currencies we are also asking pilot partners to collect additional measures where it is possible to do so. This will enable further analysis and refinement of the currencies in the future.

In this section we refer to SNOMED CT as the scheme in use. We understand that some providers are still using Read or CTV3 codes and we will accept these where necessary. By April 2020 SNOMED CT will be implemented across systems in all care settings and we anticipate that the process of submitting to the CSDS will support providers in the transfer to SNOMED CT coding.

9.2.1 Children and Young People with Disabilities (CYP)

The information below details each table for completion as well as when data should be recorded in addition to the data items described in section 8.1.

Primary Diagnosis

The recording of primary diagnosis will support the allocation of episodes of care to the CYP currency. As part of development work a list of disabling conditions has been developed. This is likely to continue to develop and evolve over the life of testing the currency. We will share the list with pilot partners during testing on a quarterly basis, or when fundamental changes or additions to the list are made.

If a pilot partner is currently collecting this as part of secondary diagnosis we will work with them to take relevant data from that field within the dataset.

Diagnosis as defined in this section should be collected for submission to the CSDS on referral. The table below shows the location within the data set which the needs of a patient should be recorded.

Table		Field	Description
CYP607	**Primary Diagnosis**	Diagnosis Scheme in use	Identifies the clinical code type 03 for SNOMED CT
		Primary Diagnosis (Coded Clinical Entry)	The SNOMED CT code as given in the Disabling Condition’s Terminology Set

Number of Needs

The number of needs can be collected as part of your current procedure or using the traffic light tool developed by Dr Horridge's team. It is intended to be used by children and families as part of each consultation so that they can prioritise the issues that matter to them and bring their concerns to each consultation. Data collected from the traffic light tool can be used to monitor the effectiveness of care as concerns and priorities change over time by reflecting present concerns with past concerns.

The template for the tool can be found here.
Dr Horridge has published an explanatory glossary of Paediatric Disability Terms which contains 297 needs and their associated SNOMED CT codes. The glossary can be found here.

Needs as defined in this section should be collected for submission to the CSDS at each contact or intervention. The table below shows the location within the data set which the needs of a patient should be recorded.

Table		Field	Description
CYP608	**Secondary Diagnosis**	Diagnosis Scheme in use	Identifies the clinical code type 03 for SNOMED CT
		Secondary Diagnosis (Coded Clinical Entry)	The SNOMED CT code as given in the Paediatric Disabilities Terminology Set (link)
		Diagnosis date	Date to associate with the contact/episode

Technological Dependency

Technological dependency is a term used to describe those who use one or more medical devices which are used to improve independence and/or participation. There are a number of technologies which may be used and these are summarised in the Paediatric Disabilities Terminology Set.

Technological dependency as defined in this section should be collected for submission to the CSDS upon referral and at each assessment. This should be recorded in the following table as shown below.

Table		Field	Description
CYP404	**Assistive Technology to Support Disability Type**	Assistive Technology Finding (SNOMED CT)	SNOMED CT codes as defined on p83-84 of the Paediatric Disabilities Terminology Set (link)

Round the Clock Care

Round the clock care is defined as where a child needs constant supervision over a 24 hour period. This should be more than is provided by the child’s parents or guardians, therefore constant clinical supervision by a professional team.

Round the clock care as defined in this section should be collected for submission to the CSDS at each patient contact. There is a specific field in which constant supervision should be reported as shown in the table below.

Table		**Field**	**Description**
CYP001	**Local Patient Identifier**	Constant Supervision indicator	Flags of Y or [Blank]

9.2.1.1 Costing the Case Mix

A currency is the combination of case mix and the resource costs required to deliver that case mix. The CYP currency case mix is based on needs that reflect the intensity and complexity of care required and this information is to be collected using the tables outlined in this section from the Community Services Data Set.

There is currently no nationally equivalent costing data set available to provide the resource costs. We will work with pilot partners to review their costing information recognising that some will have detailed patient level costing systems in place and others may not. The National Casemix Team will work with pilot partners to establish a methodology that is appropriate in each case and consolidate resource cost information across all pilot partners.
We anticipate that Children and Young People with Disabilities currency will best support a year of care payment structure that looks at the entirety of care need as the fundamental unit of currency. This dictates the duration of the pilot to ensure we track any potential seasonality and support clinical outcomes that promote stability and quality of life.

9.2.2 Long Term Conditions (LTC)

The information below details each table for completion as well as when data should be recorded in addition to the data items described in section 8.1.

Start Date

The date in which the referral request is received initiates the beginning of a currency unit. The table below shows the location within the data set which the start date should be recorded.

Table		Field	Description
CYP101	**Service or Team Referral**	Referral Request Received Date	Date for start currency

Primary Diagnosis

Primary Diagnosis should reflect the diagnosis that is being specifically treated as part of that specific referral.

The recording of primary diagnosis will support the allocation of episodes of care to the LTC currency. As part of development work a list of primary diagnoses has been developed. This is likely to continue to develop and evolve over the life of testing the currency. We will share the list with test sites on a regular basis during testing on a quarterly basis, or when fundamental changes or additions to the list are made.

Diagnosis as defined in this section should be collected for submission to the CSDS upon referral. The table below shows the possible locations within the data set which the LTC diagnosis of a patient should be recorded.

Table		Field	Description
CYP607	**Primary Diagnosis**	Diagnosis Scheme in use	Identifies the clinical code type
		Primary Diagnosis	Clinical Code (ICD10 or SNOMED CT)
		Diagnosis Date	Date to associate with the contact/episode

Other Diagnoses

It is important that we understand each patient's full list of diagnoses, if a patient is referred for a long term condition we ask that their other long term conditions are detailed to ensure we are able to see the full picture when analysing the data. To do this, please record any other condition that a patient has is reported for all patient referrals.

The list of SNOMED codes which can be submitted as additional long term conditions will be the same as provided in the Primary Diagnosis section above.

Diagnosis as defined in this section should be collected for submission to the CSDS upon referral. The table below shows the possible locations within the data set where the LTC diagnosis of a patient should be recorded.

Table		Field	Description
CYP608	**Secondary Diagnosis**	Diagnosis Scheme in use	Identifies the clinical code type
		Secondary Diagnosis	Clinical Code (ICD10 or SNOMED CT)
		Diagnosis Date	Date to associate with the contact/episode

Needs and Provision Complexity Scale

The Needs and Provision Complexity Scale combines 16 separate scores which measures a patient's health and social care needs to form an overall score. The scale as used by the currency runs from 1 to 50, combining the 16 measures covering health and social care needs to define the complexity of care needs for a patient at a specific point in their care as set out in the diagram below.

Each measure will be submitted into the CSDS as a separate assessment and these scores will be combined centrally to give the overall score.

<u>Medical Care Needs</u>

SNOMED CT Code - 1105431000000104

Score	Brief Descriptor	Details
M 0	GP occasional	GP occasional –- no regular contact – self-initiated visits to GP as required
M 1	Low level specialist	GP active monitoring - regular monitoring/ treatment by GP solely
M 2	Low level specialist	Low level specialist support e.g. for largely stable condition On-going monitoring treatment by GP with occasional specialist advice / review
M 3	Active specialist	Active specialist medical intervention required e.g. changing/unstable condition or for unresolved symptoms. Investigation or treatment requiring frequent contact with specialist medical team

Skilled Nursing Needs

SNOMED CT Code - 1105451000000106

Score	Brief Descriptor	Details
N 0	None	**No needs** for skilled nursing
N 1	Occasional	**Occasional interventions** e**.g. monthly** or less
N 2	Regular	**Regular interventions** e.g. every **1-2 weeks**
N 3	Frequent	**Frequent interventions** on a **Daily** basis or **Several times a week**

Therapy Needs - Therapy Discipline

SNOMED CT Code - 1105531000000103

Score	Brief Descriptor	Details
TD 0	None	No Therapy required
TD1	Single discipline only	Single discipline only
TD 2	Individual disciplines	Two individual disciplines may not be coordinated
TD3	Co-ordinated team	Co-ordinated interdisciplinary team - 3 or more disciplines working in a coordinated team

Therapy Needs - Therapy Intensity

SNOMED CT Code - 1105551000000105

Score	Brief Descriptor	Details
TI 0	None	**No need** for trained therapy intervention
TI 1	Occasional Review	**Requires occasional review or maintenance** programme - **Or** requires **Group therapy solely** E.g. Rehab needs met by family/care staff or self-exercise supervised by therapist e.g. every 6-8 weeks
TI 2	Regular Intervention	**Regular intervention** for maintenance / treatment e.g. **every 1-2 weeks**. OP or domiciliary treatment
TI 3	Frequent Intervention	**Requires frequent intervention** involving several sessions per week

Personal Assistant /Enabler

SNOMED CT Code - 1105511000000106

Score	Brief Descriptor	Details
PA 0	None	**No need** for assistance with community activities
PA 1	Occasional	**Occasional need** - 1-2 days per week
PA 2	Frequent	**Frequent need** - 3-5 days/week
PA 3	Daily	**Daily** - 6-7 days/week

Personal Care - Number of Carers

SNOMED CT Code - 1105471000000102

Score	Brief Descriptor	Details
CN 0	None	**No Carers** required
CN 1	1 carer	Requires **help from 1 person** for most basic care needs
CN 2	2 carers	Requires help from >2 people for most basic care needs

Personal Care - Care Frequency

SNOMED CT Code - 1105491000000103

Score	Brief Descriptor	Details
CF 0	None	**No need** for help with self-care
CF 1	Occasional need	**Occasional need** - less than daily for help with self-care, or extended activities of daily living
CF 2	Regular help x1/day	Requires **regular help once daily**
CF 3	Regular help x2/day	Requires **regular help 2-3 time**s a day - could be met by an intermittent visiting care package Able to be left safely for >4 hours or requires care / supervision at night (not waking night care
CF 4	Live in care	**Frequent or unpredictable care needs**, requiring the presence of someone most of the time Cannot be left safely for >4 hours or requires care / supervision at night (but not waking night care)
CF 5	Constant care	**Requires constant supervision**- unable to be left alone in the house, even for short periods And/or requires **waking night care** - needs >2 interventions at night

Family / Carer Support / Respite Needs - Family / Carer Support

SNOMED CT Code - 1105611000000105

Score	Brief Descriptor	Details
FC 0	None	**No need** for family / carer support
FC 1	Carer Assessment Required	**Assessment required** - for family / carer
FC2	Time-Limited family/carer support	**Time-limited family/carer support required e.g. for skills training**
FC 3	On-going family / carer support	**On-going family/carer support required** - e.g. for emotional support

Family / Carer Support / Respite Needs - Residential Respite

SNOMED CT Code - 1105621000000104

Score	Brief Descriptor	Details
RR 0	None	**No need** for residential respite care
RR 1	Occasional	Requires **occasional residential respite** - e.g. to cover holidays etc.
RR 2	Regular planned	Requires **regular planned residential respite**, but not very frequent (e.g. 1-2 weeks per 6 months)
RR 3	Frequent with back-up support	Requires **frequent planned residential care** (e.g. every 6-8 weeks) and / or **back up support at times of crisis**

Family / Carer Support / Respite Needs - Day Care

SNOMED CT Code - 1105651000000109

Score	Brief Descriptor	Details
RD 0	None	**No need** for day care
RD 1	Occasional	1-2 days per week
RD 2	Frequent	3-5 days/week

Vocational / Educational Support Needs

SNOMED CT Code - 1105571000000101

Score	Brief Descriptor	Details
VR 0	None	**No need** for vocational / educational support
VR 1	Vocational Assessment	**Requires vocational assessment / advice or educational statementing**
VR 2	On-going vocational support	**Requires on-going vocational / educational support** e.g. Access to work scheme, or withdrawal from work
VR 3	Formal vocational rehab	**Requires formal vocational / educational rehab** e.g. work prep, work re-training, supported placements

Social Work and Case Management

SNOMED CT Code - 1105591000000102

Score	Brief Descriptor	Details
S 0	None	**No needs** for social work or case management
S 1	Occasional advice	Requires **occasional intervention or available for advice** when needed e.g. contact **2-3 x per year**
S 2	Regular interventions	**Require** regular intervention or contact **e.g. every** 1-2 months
S 3	Frequent intervention	Requires **frequent intervention or contact** e.g. every **1-2 weeks**

Advocacy Needs

SNOMED CT Code - 1105671000000100

Score	Brief Descriptor	Details
AD 0	None	No needs for advocacy
AD 1	Occasional advice	**Mental capacity assessment required**
AD 2	Regular interventions	**Independent advocacy required**

Accommodation Needs - Home Living Arrangements

SNOMED CT Code - 1105711000000104

Score	Brief Descriptor	Details
AC 0	None	**No need** for special accommodation
AC 1	Restricted options	**Restricted accommodation options** (e.g. requires ground floor or lift access accommodation)
AC 2	Partially adapted	**Requires partially adapted accommodation** (e.g. rails, ramps, etc)
AC 3	Fully adapted	**Requires fully adapted accommodation** (e.g. fully wheelchair accessible)

Accommodation Needs - Sheltered and Residential Care

SNOMED CT Code - 1105711000000104

Score	Brief Descriptor	Details
AC 4	Sheltered living	**Requires sheltered living accommodation** (e.g. warden controlled)
AC 5	Small group home	**Requires supervised living arrangement e.g. small group home**
AC6	Residential care home	**Requires residential care home setting**
AC 7	Nursing home	**Requires nursing home care**
AC 8	Specialist nursing home	**Requires specialist nursing home**
AC 9	Hospice care	**Requires Hospice Care**

Specialist Equipment

SNOMED CT Code - 1105691000000101

Score	Brief Descriptor	Details
E 0	None	**No specialist equipment required**
E 1	Basic equipment	**Basic equipment required - equipment requiring professional assessment and provision** (e.g. seating, standing frame)
E 2	Specialist equipment	**Specialist equipment required -** bespoke equipment requiring professional prescription
E 3	Highly specialist equipment	**Highly specialist equipment required - bespoke equipment requiring professional prescription** (e.g. environmental control, communication aids, ventilatory support)

We expect that these measures will be collected and submitted at least annually but should be recorded when it is identified that one of the measures has changed for the patient. Each score will be recorded as an assessment as shown in the table below. The SNOMED CT codes for the NPCS are currently being developed and this section will be updated once the codes have been released.

CSDS Table		Field	Description
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Relevant Needs and Provision Complexity Scale SNOMED CT code provided in the tables above
		Score	Numerical score as defined in the tables above between 0 – 9
CYP609	**Coded Score Assessment Referral**	Coded assessment tool type	Relevant Needs and Provision Complexity Scale SNOMED CT code provided in the tables above
		Score	Numerical score as defined in the tables above between 0 – 9

Patient Activation

'Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions.

Patient activation as defined in this section should be collected and submitted annually or when a change is identified. The table below shows the location within the data set where the Patient Activation of a patient should be recorded.

Table		Field	Description
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Patient Activation SNOMED CT code - 925401000000103
		Score	1, 2, 3, 4
CYP609	**Coded Score Assessment Referral**	Coded assessment tool type	Patient Activation SNOMED CT code - 925401000000103
		Score	1, 2, 3, 4

9.2.2.1 Costing the Case Mix

A currency is the combination of case mix and the resource costs required to deliver that case mix. The LTC currency case mix is based on a combination of a person's ability and willingness to self-manage their condition and on a comprehensive assessment of their care needs. The first element is generally referred to as patient activation that has been demonstrated to have a significant impact both on clinical outcomes and the health and care resource required to achieve those outcomes. The second uses the Needs Provision and Complexity Scale which provides a score of the intensity and complexity of care needs from 0 to 50. This information is to be collected using the tables outlined in this section from the Community Services Data Set.

There is currently no nationally equivalent costing data set available to provide the resource costs. We will work with pilot partners to review their costing information recognising that some will have detailed patient level costing systems in place and others may not. The National Casemix Team will work with pilot partners to establish a methodology that is appropriate in each case and consolidate across pilot partners.

The general intentions of community care are to maintain wellbeing, ensuring long term conditions are well managed, avoid acute exacerbations, and support quality of life expectations for the patient. The model will best support a year of care that looks at the entirety of care need as the fundamental unit of currency. This dictates the duration of the pilot to ensure we track any potential seasonality and support clinical outcomes that promote stability and quality of life.

9.2.3 Single Episodes of Care (SEOC)

The information below details each table for completion as well as when data should be recorded in addition to the data items described in section 8.1.

Needs and Provision Complexity Scale

The Needs and Provision Complexity Scale combines 16 separate scores which measures a patient's health and social care needs to form an overall score. The scale as used by the currency runs from 1 to 50, combining the 16 measures covering health and social care needs to define the complexity of care needs for a patient at a specific point in their care. Each measure will be submitted into the CSDS as a separate assessment and these scores will be combined centrally to give the overall score.

Medical Care Needs

SNOMED CT Code - 1105431000000104

Score	Brief Descriptor	Details
M 0	GP occasional	GP occasional –- no regular contact – self-initiated visits to GP as required
M 1	Low level specialist	GP active monitoring - regular monitoring/ treatment by GP solely
M 2	Low level specialist	Low level specialist support e.g. for largely stable condition On-going monitoring treatment by GP with occasional specialist advice / review
M 3	Active specialist	Active specialist medical intervention required e.g. changing/unstable condition or for unresolved symptoms. Investigation or treatment requiring frequent contact with specialist medical team

Skilled Nursing Needs

SNOMED CT Code - 1105451000000106

Score	Brief Descriptor	Details
N 0	None	**No needs** for skilled nursing
N 1	Occasional	**Occasional interventions** e**.g. monthly** or less
N 2	Regular	**Regular interventions** e.g. every **1-2 weeks**
N 3	Frequent	**Frequent interventions** on a **Daily** basis or **Several times a week**

Therapy Needs - Therapy Discipline

SNOMED CT Code - 1105531000000103

Score	Brief Descriptor	Details
TD 0	None	No Therapy required
TD1	Single discipline only	Single discipline only
TD 2	Individual disciplines	Two individual disciplines may not be coordinated
TD3	Co-ordinated team	Co-ordinated interdisciplinary team - 3 or more disciplines working in a coordinated team

Therapy Needs - Therapy Intensity

SNOMED CT Code - 1105551000000105

Score	Brief Descriptor	Details
TI 0	None	**No need** for trained therapy intervention
TI 1	Occasional Review	**Requires occasional review or maintenance** programme - **Or** requires **Group therapy solely** E.g. Rehab needs met by family/care staff or self-exercise supervised by therapist e.g. every 6-8 weeks
TI 2	Regular Intervention	**Regular intervention** for maintenance / treatment e.g. **every 1-2 weeks**. OP or domiciliary treatment
TI 3	Frequent Intervention	**Requires frequent intervention** involving several sessions per week

Personal Assistant /Enabler

SNOMED CT Code - 1105511000000106

Score	Brief Descriptor	Details
PA 0	None	**No need** for assistance with community activities
PA 1	Occasional	**Occasional need** - 1-2 days per week
PA 2	Frequent	**Frequent need** - 3-5 days/week
PA 3	Daily	**Daily** - 6-7 days/week

Personal Care - Number of Carers

SNOMED CT Code - 1105471000000102

Score	Brief Descriptor	Details
CN 0	None	**No Carers** required
CN 1	1 carer	Requires **help from 1 person** for most basic care needs
CN 2	2 carers	Requires help from $\geq$2 people for most basic care needs

Personal Care - Care Frequency

SNOMED CT Code - 1105491000000103

Score	Brief Descriptor	Details
CF 0	None	**No need** for help with self-care
CF 1	Occasional need	**Occasional need** - less than daily for help with self-care, or extended activities of daily living
CF 2	Regular help x1/day	Requires **regular help once daily**
CF 3	Regular help x2/day	Requires **regular help 2-3 time**s a day - could be met by an intermittent visiting care package Able to be left safely for >4 hours or requires care / supervision at night (not waking night care
CF 4	Live in care	**Frequent or unpredictable care needs**, requiring the presence of someone most of the time Cannot be left safely for >4 hours or requires care / supervision at night (but not waking night care)
CF 5	Constant care	**Requires constant supervision**- unable to be left alone in the house, even for short periods And/or requires **waking night care** - needs >2 interventions at night

Family / Carer Support / Respite Needs - Family / Carer Support

SNOMED CT Code - 1105611000000105

Score	Brief Descriptor	Details
FC 0	None	**No need** for family / carer support
FC 1	Carer Assessment Required	**Assessment required** - for family / carer
FC2	Time-Limited family/carer support	**Time-limited family/carer support required e.g. for skills training**
FC 3	On-going family / carer support	**On-going family/carer support required** - e.g. for emotional support

Family / Carer Support / Respite Needs - Residential Respite

SNOMED CT Code - 1105621000000104

Score	**Brief Descriptor**	**Details**
RR 0	None	**No need** for residential respite care
RR 1	Occasional	Requires **occasional residential respite** - e.g. to cover holidays etc.
RR 2	Regular planned	Requires **regular planned residential respite**, but not very frequent (e.g. 1-2 weeks per 6 months)
RR 3	Frequent with back-up support	Requires **frequent planned residential care** (e.g. every 6-8 weeks) and / or **back up support at times of crisis**

Family / Carer Support / Respite Needs - Day Care

SNOMED CT Code - 1105651000000109

Score	**Brief Descriptor**	**Details**
RD 0	None	**No need** for day care
RD 1	Occasional	1-2 days per week
RD 2	Frequent	3-5 days/week

Vocational / Educational Support Needs

SNOMED CT Code - 1105571000000101

Score	**Brief Descriptor**	**Details**
VR 0	None	**No need** for vocational / educational support
VR 1	Vocational Assessment	**Requires vocational assessment / advice or educational statementing**
VR 2	On-going vocational support	**Requires on-going vocational / educational support** e.g. Access to work scheme, or withdrawal from work
VR 3	Formal vocational rehab	**Requires formal vocational / educational rehab** e.g. work prep, work re-training, supported placements

Social Work and Case Management

SNOMED CT Code - 1105591000000102

Score	Brief Descriptor	Details
S 0	None	**No needs** for social work or case management
S 1	Occasional advice	Requires **occasional intervention or available for advice** when needed e.g. contact **2-3 x per year**
S 2	Regular interventions	**Require** regular intervention or contact **e.g. every** 1-2 months
S 3	Frequent intervention	Requires **frequent intervention or contact** e.g. every **1-2 weeks**

Advocacy Needs

SNOMED CT Code - 1105671000000100

Score	Brief Descriptor	Details
AD 0	None	No needs for advocacy
AD 1	Occasional advice	**Mental capacity assessment required**
AD 2	Regular interventions	**Independent advocacy required**

Accommodation Needs - Home Living Arrangements

SNOMED CT Code - 1105711000000104

Score	Brief Descriptor	Details
AC 0	None	**No need** for special accommodation
AC 1	Restricted options	**Restricted accommodation options** (e.g. requires ground floor or lift access accommodation)
AC 2	Partially adapted	**Requires partially adapted accommodation** (e.g. rails, ramps, etc)
AC 3	Fully adapted	**Requires fully adapted accommodation** (e.g. fully wheelchair accessible)

Accommodation Needs - Sheltered and Residential Care

SNOMED CT Code - 1105711000000104

Score	Brief Descriptor	Details
AC 4	Sheltered living	**Requires sheltered living accommodation** (e.g. warden controlled)
AC 5	Small group home	**Requires supervised living arrangement e.g. small group home**
AC6	Residential care home	**Requires residential care home setting**
AC 7	Nursing home	**Requires nursing home care**
AC 8	Specialist nursing home	**Requires specialist nursing home**
AC 9	Hospice care	**Requires Hospice Care**

Specialist Equipment

SNOMED CT Code - 1105691000000101

Score	Brief Descriptor	Details
E 0	None	**No specialist equipment required**
E 1	Basic equipment	**Basic equipment required - equipment requiring professional assessment and provision** (e.g. seating, standing frame)
E 2	Specialist equipment	**Specialist equipment required -** bespoke equipment requiring professional prescription
E 3	Highly specialist equipment	**Highly specialist equipment required - bespoke equipment requiring professional prescription** **(**e.g. environmental control, communication aids, ventilatory support)

We expect that these measures will be collected and submitted at least annually but should be recorded when it is identified that one of the measures has changed for the patient. Each score will be recorded as an assessment as shown in the table below. The SNOMED CT codes for the NPCS are currently being developed and this section will be updated once the codes have been released.

CSDS Table		Field	Description
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Relevant Needs and Provision Complexity Scale SNOMED CT code provided in the tables above
		Score	Numerical score as defined in the tables above between 0 – 9
CYP609	**Coded Score Assessment Referral**	Coded assessment tool type	Relevant Needs and Provision Complexity Scale SNOMED CT code provided in the tables above
		Score	Numerical score as defined in the tables above between 0 – 9

Patient Activation

‘Patient activation’ describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions.

Patient activation as defined in this section should be collected and submitted annually or when a change is identified. The table below shows the location within the data set where the Patient Activation of a patient should be recorded.

Table		Field	Description
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Patient Activation SNOMED CT code - 925401000000103
		Score	1, 2, 3, 4
CYP609	**Coded Score Assessment Referral**	Coded assessment tool type	Patient Activation SNOMED CT code - 925401000000103
		Score	1, 2, 3, 4

9.2.3.1 Costing the Case Mix

A currency is the combination of case mix and the resource costs required to deliver that case mix. The SEOC currency uses the same baseline model as LTC where case mix is based on a combination of a person’s ability and willingness to self-manage their condition and on a comprehensive assessment of their care needs. The first element is generally referred to as patient activation that has been demonstrated to have a significant impact both on clinical outcomes and the health and care resource required to achieve those outcomes. The second uses the Needs Provision and Complexity Scale (NPCS) which provides a score of the intensity and complexity of care needs from 0 to 50. This information is to be collected using the tables outlined in this section from the Community Services Data Set. Resource costs will be directly proportional to NPCS score adjusted by the level of patient activation.

There is currently no nationally equivalent costing data set available to provide the resource costs. We will work with pilot partners to review their costing information recognising that some will have detailed patient level costing systems in place and others may not. The National Casemix Team will work with pilot partners to establish a methodology that is appropriate in each case and consolidate across pilot partners.

The Single Episodes of Care Model naturally lends itself to an episode of care as the fundamental unit. The currency model can support a variety of care durations for example 6 weeks speech and language therapy following a stroke or 12 weeks rehabilitation following complex injury.

9.2.4 Frailty

The information below details each table for completion as well as when data should be recorded in addition to the data items described in section 8.1.

Diagnosis

Diagnosis may be collected in a number of fields within the CSDS and for the purpose of the currency we require that for frailty related episodes the primary diagnosis is listed as Frailty.

The SNOMED CT codes for frailty are as follows:
Mild Frailty - 2373871000000117
Moderate Frailty - 2373951000000116
Severe Frailty - 2374011000000117

Diagnosis as defined in this section should be collected for submission to the CSDS upon referral. The table below shows the possible locations within the data set where the frailty diagnosis of a patient should be recorded.

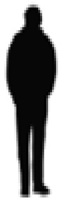
Table		Field	Description
CYP607	**Primary Diagnosis**	Diagnosis Scheme in use	Identifies the clinical code type
		Primary Diagnosis	SNOMED CT code – As defined in the section above
		Diagnosis Date	Date to associate with the contact/episode

Canadian Study of Health and Aging Clinical Frailty Scale (CFS)

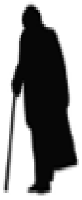
The CFS is a 9 point scale which measures a person's frailty from 1 – very fit to 9 – terminally ill. The following diagram defines each point in the scale.

1 Very Fit - People who are robust, active, energetic and motivated. these people commonly exercise regularly. They are among the firttest for their age.

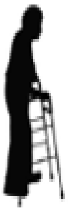
2 Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionall, e.g. seasonally.



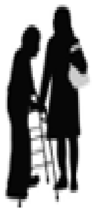
3 Managing Well - People whose medicak problems are well controlled, but are not regularly active beyond routine walking.



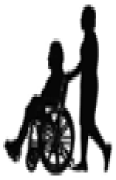
4 Vulnerable - While not dependant on others for daily help, often symptons limit activities. A common complaint is being "slowed up", and/or being tired during the day.



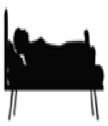
5 Midly Frail - These people often have more evident slowing, and need help in high order IADLS (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preperation and housework.



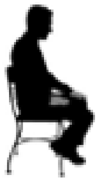
6 Moderatley Frail - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help bathing and might need minimal assistance (cuing, standby) with dressing).



7 Severley Frail- Completely dependant for personal care, from whatever cause (Physical or cognitive). Even so, they seem stable and not at high risk of dying (within - 6 months)



8 Very Severely Frail - Completely dependant, approaching the end of lilfe. Typically, they could not recover even from a minor illness.



9 Terminally Ill- Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia
The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

The CFS as defined above should be recorded on referral and then regularly reassessed and submitted when it changes. As a minimum we expect that this will be reassessed at each review which depending on local procedure could be every three, six or twelve months. The table below shows the location within the data set where the CFS of a patient should be recorded.

Table		Field	Description
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Canadian Study of Health and Aging clinical frailty scale SNOMED CT code - 445414007
		Score	1, 2, 3, 4, 5, 6, 7, 8, 9
CYP609	**Coded Score Assessment Referral**	Coded assessment tool type	Canadian Study of Health and Aging clinical frailty scale SNOMED CT code - 445414007
		Score	1, 2, 3, 4, 5, 6, 7, 8, 9

9.2.4.1 Costing the Case Mix

A currency is the combination of case mix and the resource costs required to deliver that case mix. The Frailty currency case mix is based on interventions that are directly related to the level of frailty and the potential outcomes that are reflected in the currency model. information is to be collected using the tables outlined in this section from the Community Services Data Set.

There is currently no nationally equivalent costing data set available to provide the resource costs directly associated with interventions for the management of frailty. We will work with pilot partners to review their costing information recognising that some will have detailed patient level costing systems in place and others may not. The National Casemix Team will work with pilot partners to establish a methodology that is appropriate in each case and consolidate across pilot partners.

The focus of frailty is healthy aging, frailty as a diagnosis is seen as a long-term condition that when well managed has a 10 to 15-year duration. The Model will best support a year of care structure that looks at the entirety of care need covering a series of linked interventions to maintain or improve wellbeing as the fundamental unit of currency. This dictates the duration of the pilot to ensure we track any potential seasonality and support clinical outcomes that promote stability and quality of life.

9.2.5 Last Year of Life (LYOL)

The information below details each table for completion as well as when data should be recorded in addition to the data items described in section 8.1.

Phase of Illness

The internationally validated Phase of Illness model consists of five phases; Stable, Unstable, Deteriorating, Dying and Deceased as defined below.

Start of phase	End of phase
Stable: Patient problems and symptoms are adequately controlled by established plan of care and • Further interventions planned to maintain symptom control and quality of life **and** • Family/carer situation is relatively stable and no new issues are apparent	**Stable:** • The needs of the patient and or family/carer increase, requiring changes to the existing care plan (i.e. the patient is now unstable, deteriorating or terminal)
Unstable: An urgent change in the plan of care or emergency treatment is required **because** • Patient experiences a new problem that was not anticipated in the existing plan of care, **and/or** • Patient experiences a rapid increase in the severity of a current problem; **and/or** • Family/ carers' experience changes which impact on patient care	**Unstable:** • The new care plan is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. the patient is now stable or deteriorating) **and/or** • Death is likely within days (i.e. patient is now terminal)
Deteriorating: The care plan is addressing anticipated needs but requires periodic review **because** • Patient's overall function is declining **and** • Patient experiences an anticipated and gradual worsening of existing problem **and/or** • Patient experiences a new but anticipated problem **and/or** • Family/carers experience gradual worsening distress that is anticipated but impacts on the patient care	**Deteriorating:** • Patient condition plateaus (i.e. patient is now stable) **or** • An urgent change in the care plan or emergency treatment is required **and/or** • Family/ carers experience a sudden change in their situation that impacts on patient care, and requires urgent intervention (i.e. patient is now unstable) **or** • Death is likely within days (i.e. patient is now terminal)
Dying: Death is likely within days	**Dying:** • Patient dies **or** • Patient condition changes and death is no longer likely within days (i.e. patient is now stable, or deteriorating)
Deceased: Patient has died; bereavement care provided to family/carer is documented in the deceased patient's clinical record.	**Deceased:** Case closed.

Phase of illness as defined in this section should be collected for submission to the CSDS when the patient care plan is established or when a change is needed to the patient's care plan, for example, when the phase of illness changes. The table below shows the location within the data set where the phase of illness of a patient should be recorded.

Table		**Field**	**Description**
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Phase of Illness SNOMED Code - 1092791000000107
		Score	Relevant score
CYP609	**Coded Score Assessment Referral**	Coded assessment tool type	Phase of Illness SNOMED Code - 1092791000000107
		Score	Relevant score

Australian Modified Karnofsky Performance Scale (AKPS)

The Australian Modified Karnofsky Performance Scale (AKPS) sets out the functional status of a patient. It is based on a scoring system from 0-100 in increments of 10 as set out in the table below. For the currency this is expressed by three broad categories of high, medium and low. This should be collected and recorded as part of your locally defined clinical processes and should coincide with regular patient contact where functional status will be recorded.

	Status Score	**Descriptor**
High	100%	Normal no complaints; no evidence of disease.
	90%	Able to carry on normal activity; minor signs or symptoms of disease.
	80%	Normal activity with effort; some signs or symptoms of disease.
Medium	70%	Cares for self; unable to carry on normal activity or to do active work.
	60%	Requires occasional assistance but is able to care for most personal needs.
	50%	Requires considerable assistance and frequent medical care.
Low	40%	In bed more than 50% of the time.
	30%	Almost completely bedfast
	20%	Totally bedfast and requiring extensive nursing care by professionals and/or family
	10%	Comatose or barely arousable
	0%	Dead

AKPS as defined in this section should be collected for submission to the CSDS when the patient care plan is established or when a change is needed to the patient's care plan, for example, when the phase of illness changes. The table below shows the location within the data set where the AKPS of a patient should be recorded.

Table		Field	Description
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Karnofsky SNOMED Assessment SNOMED code: 901541000000107
		Score	0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100
CYP609	**Coded Score Assessment Referral**	Coded assessment tool type	Karnofsky SNOMED Assessment SNOMED code: 901541000000107
		Score	0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100

Additional Data

Integrated Palliative Outcome Scale (IPOS)

IPOS is a measure of global symptom burden which includes items that measure physical, psychosocial, social and spiritual domains in line with a holistic assessment. It allows patients to list their main concerns, to add other symptoms they are experiencing, and to state whether they have unmet information or practical needs.

The use of IPOS further enhances the commissioning for outcomes, value and care possibilities of the model. We would like to encourage pilot partners to collect this information to enable IPOS to be revisited in the analysis of the data at a later stage.

IPOS as defined in this section should be collected for submission to the CSDS when the patient care plan is established or when a change is needed to the patient’s care plan, for example, when the phase of illness changes. The table below shows the location within the data set where the IPOS of a patient should be recorded.

Table		Field	Description
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Integrated Palliative Outcome Scale Assessment SNOMED code: 1033321000000108
		Score	0, 1, 2, 3, 4, 5
CYP609	**Coded Score Assessment Referral**	Coded assessment tool type	Integrated Palliative Outcome Scale Assessment SNOMED code: 1033321000000108
		Score	0, 1, 2, 3, 4, 5

Palliative Care Problem Severity Score (PCPSS)

A clinician rated assessment of problems over a 24hour period, it consists of global assessment of four palliative care domains to summarise palliative care needs and plan care. The severity of problems are rated and responded to using a scale where: 0= Absent, 1=Mild, 2=Moderate, 3=Severe

Domain 1 – Pain
The overall severity of pain problems for the patient
SNOMED CT code – 902501000000103

Domain 2 – Other Symptoms
The overall severity of problems relating to one or more symptoms other than pain.
SNOMED CT code – 902511000000101

Domain 3 – Psychological / Spiritual
The severity of problems relating to the patient's psychological or spiritual wellbeing. There may be one of more issues.
SNOMED CT code – 902521000000107

Domain 4 – Family / Carer
The problems associated with the patient's condition or palliative care needs. Family / Carer do not need to be present to assess needs as written, verbal or observational information may be used.
SNOMED CT code – 902531000000109

PCPSS is not currently clinically validated and therefore has not been included as a score within the currency model, however we would like to encourage pilot providers to collect this information to enable PCPSS to be revisited in the analysis of the data at a later stage.

PCPSS as defined in this section should be collected for submission to the CSDS when the patient care plan is established or when a change is needed to the patient's care plan, for example, when the phase of illness changes. The table below shows the location within the data set where the PCPSS of a patient should be recorded.

Table		**Field**	**Description**
CYP612	**Coded Score Assessment Contact**	Coded assessment tool type	Palliative Care Problem Severity Score Assessment SNOMED code: As shown for specific domains above
		Score	0, 1, 2, 3
CYP612	**Coded Score Assessment Referral**	Coded assessment tool type	Palliative Care Problem Severity Score Assessment SNOMED code: As shown for specific domains above
		Score	0, 1, 2, 3

9.2.5.1 Costing the Case Mix

A currency is the combination of case mix and the resource costs required to deliver that case mix. The LYOL currency case mix is based on work originating from the specialist palliative care currency development and uses the community setting applied to general end of life care. As such we already have indicative cost relativities.

We will work with pilot partners to revisit the cost structures associated with each of the phases of illness and levels of functional ability. We will work with pilot partners to review their costing information recognising that some will have detailed patient level costing systems in place and others may not. The National Casemix Team will work with pilot partners to establish a methodology that is appropriate in each case and consolidate across pilot partners.

When the specialist palliative care currency was developed the costing model looked at spell of care as the fundamental unit that included one or more phase of Illness. As LYOL focuses on choice in general end of life care we anticipate less variation over the course of a year of care therefore the fundamental unit of the model is a year of care this should support the personalisation agenda continuing health care national.

9.3 Activity and Resourcing Data

The information described so far will facilitate the allocation of each patient to the case mix of that currency. In order to understand the resources required we will also require activity based data to understand the homogeneity of each currency unit.

In order to do so, we will need to understand the following information –

- Referral information
- Care contact information
- Care activity information

The majority of this information can be submitted in the CYP101, CYP201, CYP202 tables. More information can be found in the Technical Output Specification available here.

10 Requirements of Pilot Partners

What type of organisation do we want as Pilots?

We are looking for between 20 and 30 pilot sites to ensure that we have a mix of organisations testing all currencies and individual currencies.
We are interested in engaging with organisations that can test one or more currencies. If your organisation is able to test all currencies we especially want to hear from you.

We recognise that community sector providers come in all shapes and sizes. The size of the organisation does not matter; we are looking for providers of all sizes and types, to get the broadest possible representation of organisations. It could be a partnership of several organisations that represents an STP footprint, a large Community Trust, local Community Interest Company (CIC), Independent Provider or any small organisation that provides a publicly funded community healthcare service.

We also recognise that community sector providers have variable levels of digital informatics maturity. We are not just looking for digitally mature organisations, with substantial informatics resources of their own, although of course that helps particularly where they are potentially submitting large volumes of data monthly. Any organisation that would like to participate, even if they are not sure they would be able to meet the submission requirements or expect they might struggle to do so is welcome. We are very interested in engaging with you and finding ways to help you participate and contribute. It is important for us to understand the barriers to using currencies and the challenges that you face in collecting, recording and submitting data to national data sets to enhance our learning.

What we are looking for from Pilots

1. A Pilot will agree to collect detailed patient level information for each currency they agree to test and make regular monthly submissions to CSDS for the duration of the testing period
2. Pilot organisations will be invited to join the task group for each currency they agree to test. Meetings will be held monthly or as required by teleconference with occasional face-to-face meetings
3. Pilots will participate in qualitative surveys to assess ease of use and level of understanding for each currency
4. Pilots will participate in workshops to share the outcomes of the data analysis, and learning from use of the currencies, and to discuss the rules that will be required to manage the interaction of each currency is a comprehensive community model
5. Where possible, pilots will provide patient level cost data for the care delivered against each currency either using the road map data collection for PLICS or their own patient level cost systems

11 Benefits for Pilot Partners and support available

What support we will provide for Pilot Partners

1. We will meet each potential pilot site to explain the process, answer concerns and understand local constraints
2. We will provide a detailed testing and guidance document
3. We will run start up workshops for pilot partners in London, Leeds and Birmingham
4. We will provide a dedicated email address for questions and answers
5. We will establish regular meetings for feedback and learning, using the most appropriate method for the content of the meeting
6. We will maintain and regularly distribute a Frequently Asked Questions document to share learning and reference
7. We will provide registration assistance and initial submission support from NHS Digital’s Information Analysis Team for the Community Services Data Set
8. As the process develops we will provide updates on the analysis of data submitted
9. We will involve pilot partners in the review of findings and any potential re-definition of the currencies
10. We will engage with pilot partners through workshops and direct one-to-one engagement to determine the rules governing how individual currencies should be used with each other as part of comprehensive community healthcare currency
11. The Pricing Team will provide single point of contact for all support to pilot partners

Pilot providers will benefit from having a consistent and transparent vocabulary for commissioners and providers to use. The use of currencies can enable a better understanding of the patient populations that providers serve and can be a path towards better understanding of the costs incurred in treating patients.

If you would like to be a Pilot Partner or would like more information, please contact england.communitycurrencies@nhs.net.

12 Alternative Testing Arrangements – Data Partners

The Data Pilot arrangement is an alternative option for those providers that are not able to spare the resource to meet the requirements described in Section 7. This is a lighter version of the testing process that builds on the mandated requirement to flow data that is collected into the national data set. This may suit organisations already collecting and submitting data to the CSDS who are working to improve the quality of the data submitted to fully reflect the work they do.

We are asking that data partners to collect and submit data to the CSDS as requested in this document and validate their data to ensure that it meets the requirements for the currency. The data will be included in the analysis to test the feasibility of the currencies and we will provide regular updates on the progress of this work.

If you would like to be a Data Partner or would like more information, please contact england.communitycurrencies@nhs.net.

13 Annex

13.1 Annex A – Group Membership

Membership of the Task and Finish Groups Responsible for the Development of the Currencies

Children and Young People

Dr Claire Lemer (Chair)	NHS England – Associate National Clinical Director
Dr Ronny Cheung	Evelina – Acute Paediatrician
Dr Robert Klaber	St Mary's ICL – Consultant Paediatrician
Dr Mando Watson	St Mary's ICL – Consultant Paediatrician
Dr Cliona Ni Bhrolchain	Wirral – Consultant Paediatrician
Dr Gabriel Whitlingum	Hampshire – Consultant Paediatrician
Dr Karen Horridge	Sunderland – Consultant Paediatrician
Jola Forys	QNI – Team Leader Children's Community Nursing Services
Kath Evans	NHS England – Head of Patient Experience Maternity, Neonatal & CYP
Katrina McNamara	TfSL - Director of Service Development and Improvement
Sharon Thandi	NHS Digital
Nicholas Aldridge	NHS Digital
Neil Gallagher	Guy's and St Thomas' NHS FT
Simon Blazer	Guy's and St Thomas' NHS FT
Lucy Ellis	NHS England
Leslie Cove	NHS Improvement – Pricing Team
Sue Nowak	NHS England – Head of Pricing Development
Gary Stinson	NHS England - Pricing Development Lead
Dave Allen	NHS Digital – Senior Case Mix Consultant
Barry James	NHS England – Pricing Development Manager Community
Sara Brunt	NHS England – Pricing Development Manager

Long Term Conditions

Gareth Howells	Birmingham Community Healthcare Foundation Trust – Director of Nursing and Therapies
Dr Ollie Hart	Sheffield GP Practice – RCGP Clinical Champion for Collaborative Care Planning
Dr Nilesh Bharakda	Hillingdon CCG - GP Governing Body LTC Lead
Alison Hawley	AGEM CSU – Programme Manager Service Transformation
Fiona McHugh	London North West Healthcare NHS Trust
Nina Melville	NCHC – Service Manager
Mandy Bereford	NCHC - Community Respiratory Nurse Specialist
Dawn Roberts	QHI Oxford Health – QN Clinical Development Lead for DN Services
Dawn Murphy	HFMA – Thameside & Glossop Integrated Care NHS Trust
Leslie Cove	NHS Improvement – Pricing Team
Matt Miles	Lincolnshire Community Health – Cost Accountant
Dr Garry Tan	Oxford University Hospitals NHS FT - Consultant
Alan Collinge	Birmingham Community Healthcare NHS FT - Business Intelligence & Information Services Manager
Alex Grimsley	Birmingham Community Healthcare NHS FT – Senior Data Architect
Jo-Anna Holmes	Age UK

Jitesh Sudera	Personalised Care Group
Sarah Marsh	NHS England – Programme Manager Long Term Conditions
Sue Nowak	NHS England – Head of Pricing Development
Gary Stinson	NHS England – Pricing Development Lead
Dave Allen	NHS Digital – Senior Case Mix Consultant
Barry James	NHS England - Pricing Development Manager Community Services

Single Episodes of Care

Shelagh Morris (Chair)	NHS England - Deputy Chief Allied Health Professions England
Kathryn Evans	NHS England - Nursing Community Lead
Rebekah Matthews	Sheffield Hospitals – Integrated Pathway Manager
Michael Folan	NHS England – AHP Informatics Lead
Maureen Drake	NHS England – AHP Outcomes
Matt Miles	Lincolnshire Community Healthcare Trust – Cost Accountant
Steve Tolan	Chartered Society of Physiotherapy
Jeanne Davey	Richmond and Hounslow Community Healthcare Trust - Response and Rehabilitation Service Manager
Priya Arjan	London North West Health Care Trust – Cost Accountant
Steve Tolan	Chartered Society of Physiotherapy
Kiri Elliott	The Association of UK Dietitians – Policy Officer
Kamini Gadhok	Royal College of Speech & Language Therapists – Chief Executive
Kathryn Moyse	Royal College of Speech & Language Therapists
Paul Cooper	Royal College of Occupational Therapists - Professional Advisor
Leslie Cove	NHS Improvement - Pricing
Dave Allen	NHS Digital - Senior Case Mix Consultant
Sue Nowak	NHS England - Head of Pricing Development
Barry James	NHS England - Pricing Development Manager for Community Services
Gary Stinson	NHS England - Pricing Development Lead

Frailty

Prof Martin Vernon	NHS England - National Clinical Director Older People and Frailty
Dr Bola Owolabi	Derby CHSNHSFT - Deputy Medical Director
Dr Peter Woodhouse	NCHC – Consultant Older Peoples Medicine
Ian Wilkinson	Oldham CCG – Chief Clinical Officer
Maria Howden	Thanet CCG – Head of Membership Development
Alison Hawley	AGEM CSU – Programme Manager Service Transformation
Elliot Gyimah	North West London Foundation Trust
Lisa Cottrell	CFMT Manchester – QN and Nurse Consultant for Older People and Frailty
Leslie Cove	NHS Improvement – Pricing Team
Matt Thomas	British Geriatric Society
Tom Gentry	Age UK
Arvind Kumar	North Somerset Community Partnership
David Bramley	NHS England – Programme Manager Older People and Frailty
Sue Nowak	NHS England – Head of Pricing Development
Gary Stinson	NHS England – Pricing Development Lead
Dave Allen	NHS Digital – Senior Case Mix Consultant

Barry James	NHS England - Pricing Development Manager Community Services

Last Year of Life

Prof Bee Wee	NHS England - National Clinical Director EOLC
Prof Fliss Murtagh	Hull York Med School – ANCD CYP – Prof of Palliative Medicine
Dr Sarah Wells	Marie Curie West Midlands – Project Consultant for Paperless Hospices
Dr John Hughes	Sue Ryder –Medical Director
Dr Peter Gabbitas	Marie Curie – Executive Director of Caring Services & Partnership
Rob Smith	Derby THNHSFT – MacMillan Project Manager for Palliative Medicine
Elizabeth Alderton	North East London Foundation Trust – QN and District Nurse Team
Eileen Mitchell	NHS England – Patient Choice
Laura Schubert	NHS England – Patient Choice
Jenny Kenward	NHS England – Head of Patient Experience Community Services
Leslie Carter	AGE UK - Interim Head of Health influencing
Jonathan Ellis	Hospice UK – Director of Policy and Advocacy
Leslie Cove	NHS Improvement – Pricing Team
Greg Dalton	NHS Improvement – Pricing Team
Louise Corson	NHS England – Programme Manager End of Life Care
Sue Nowak	NHS England – Head of Pricing Development
Gary Stinson	NHS England – Pricing Development Lead
Dave Allen	NHS Digital – Senior Case Mix Consultant
Barry James	NHS England – Pricing Development Manager Community Services

13.2 Annex B – Expert Reference Group - Terms of Reference

Background

Since the beginning of PbR (Payment by Results) it has been an ambition to establish currencies for community services; as most community services are commissioned on a block contract. However, priorities in other areas and the difficulty of gathering evidence to support development prevented the ambition being realised.

It is widely recognised that the future of community services is at the heart of delivering the five year forward view and long term plan. It is equally recognised that there remains a significant lack of quality data visible at national level. Work is progressing to correct this with the establishment of a national Community Services Data Set due to begin collecting baseline data from November 2017. There are plans to enhance this data through a phase II project as well as business as usual review and revision.

It was felt that the time was right to give priority to developing community healthcare currencies to support the ambitions of the five year forward view and long term plan.

This project is commissioned by NHS England supported by NHS Improvement and its outcomes will be reported through the Joint NHS E / NHS I National Tariff Overall Programme Board via Work Stream 3 (Currency Development) Programme Board.

Definition

Currency

A currency is a means of classifying and grouping people with broadly similar health and social care needs and the resources required to meet them. It should also improve understanding of the outcomes achieved and enable meaningful comparison of different models of care, for example by comparing outcomes for similar groups of people.

Community Services

Community Services is undergoing a process of major transformation, new care models and closer collaborations within a place and population based total system of care with the patient at its centre make traditionally used definitions no long fully fit for purpose such as:

1. Monitor defined CHS in 2016 as: *Physical health services delivered outside of hospital settings and in community settings (e.g. community hospitals, clinics, GP practices, schools and patients' homes).*
2. NHS Confederation defined CHS as: *teams of nurses and therapists who coordinate care, working with professions including General Practitioners and Social care.*

The first is essentially a service form and place based definition. The aims of this project require a condition, needs or pathway based definition that permits safe, effective, long term patient centred care where needs and preferences are determined, yielding positive patient outcomes, to be provided irrespective of location of care.

The second is also defined in a service and professionally centred way; therefore it is not led by the needs, preferences and circumstances of patients and their families. Community currencies present an opportunity to refocus away from service and professional definitions towards needs based systems of service design, delivery and payment. This project will be defined by the collective definitions of health care provided under the five headings of: children and young people; long term conditions; single episodes of care; frailty and end of life care. The ambition is that these currencies create the right conditions for integration of community based care across traditional, professional and organisational boundaries.

Objectives

The objectives for the community healthcare currencies in each of the five identified areas are set out against the challenges presented in the Five Year Forward View, these challenges are:-

The Health and Wellbeing Gap

Promote wellness through preventative interventions and incentivise greater patient empowerment through self-management and engagement.

The Care and Quality Gap

Promote collaborative working across service boundaries by focusing on the needs of staff and patients to deliver the outcomes they want. We will use outcomes as part of the currency framework to measure the effectiveness of care from both a clinical and patient perspective.

The Funding and Finance Gap

Using outcomes as part of the currency framework to measure the efficiency of care delivered against agreed process markers.

Alignment with other Community Programmes

This project is taking place at a time when community services are the focus of many other programmes not only within NHS England but across all ALBs and DH, the following is a list that the project manager is directly engaged with or aware of their work, all will be considered when preparing papers and supporting the work of this group and the task groups:

- Community Services Data Set – National Information Board Project NHS Digital and NHS England
- Patient Level Information and Costing Standards – National Information Board project NHS Improvement and NHS Digital
- Carter 2 – Community Services unwarranted variation – NHS Improvement
- CROC – Coordinating Reallocation of Costs – NHS England Right Care
- Revising the Community Allocation Formula – NHS England Commissioning Strategy
- New Care Models vanguard programme – NHS England
- Right Care and GIRFT– NHS England Right Care Team
- Personal Health Budgets - NHS England Personal Health Budgets Team
- Nursing Home Registration Data Set – Collaboration of CQC, NHS Digital and NHS England

- Community Nursing Framework – NHS England Nursing Directorate
- Ambitions Framework for EOLC – Coalition of 28 members from across the sector supported by NHS England

Purpose of the Expert Reference Group

- To guide the development and testing of community health care currencies
- To review and approve the principles, utility and direction of currency design presented by the task groups
- To advise on other streams of work that have a potential to impact or be impacted by currency development
- To advise on risks and issues and support their mitigation and resolution
- To advise and guide on the impact and consequences of design decisions
- To advise, coordinate and review the work of task groups
- To recommend actions to be taken regard to system blocks and competing priorities both internal to NHS England, other ALB's, DH and external stakeholders
- To review and approve technical recommendations
- To review and approve engagement and communication plans
- To review technical publications
- To coordinate with other technical streams of work and advise on data sources

Guiding Principles for the work of the Group

In meeting the purpose of the group set out above, members are asked to consider what makes a good currency. For this, we can use as guiding principles international best practice definitions of what makes a good currency.

A good currency is defined by four key attributes, the currency must:

Make sense to health and care professionals – we are looking to develop currencies for care, that are person centred needs based and outcome driven. That promotes wellness, incentivise collaborative care provision and activate self-supported care management.

Support the commissioning process – we are looking for a currency that can support population and place level budgets, service planning, as well as personalised budgets and continuing healthcare, and be equally applicable in environments where health and social care budgets have been combined as well as where they remain separate.

Be simple to use – the information that supports the classification should come from the information collected naturally as part of the routine business of providing care. Data should be collected once and used many times, not only at a national level but at a local operational level too.

Be analytically robust - Each unit of currency should be discrete, there should be no ambiguity in boundaries and no overlap between one currency unit and another.

In addition, each currency should support the equality and health inequalities agenda avoiding any direct or unintended impact on the nine protected areas.

The group should refer to these attributes when considering currency models, testing and communication frameworks and the messaging around them.

The litmus test of each currency is the triple aim of better outcomes, better experiences for people and professionals, and better use of resources.

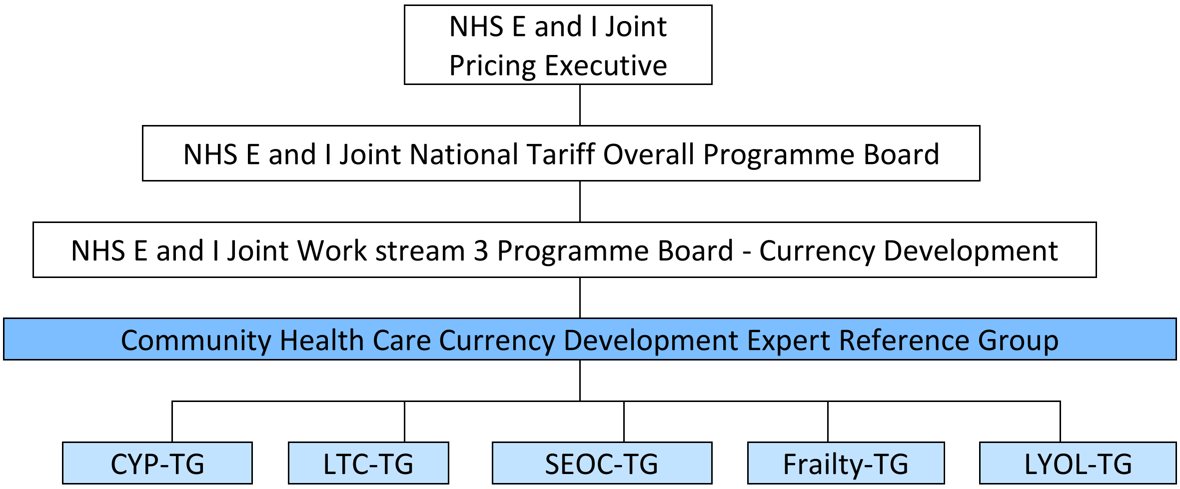
Duration
Duration of the ERG will be reflected by the life of the development cycle to publication of the currencies that collectively define community healthcare, projected deliverable dates for each of the task groups is as follows:

CYP	Currencies for testing in practice	1st December 2017
	Publication of guidance documents for testing	2nd February 2018
LTC	Currencies for testing in practice	31st January 2018
	Publication of guidance documents for testing	31st March 2018
SEOC	Currencies for testing in practice	16th February 2018
	Publication of guidance documents for testing	6th April 2018
Frailty	Currencies for testing in practice	16th February 2018
	Publication of guidance documents for testing	6th April 2018
EOLC	Currencies for testing in practice	15th January 2018
	Publication of guidance documents for testing	12th March 2018

Frequency of Meetings
Frequency or meetings to be determined by the group anticipated to be quarterly, varying according to the need of the development cycle.

Means of Meeting
Meetings will be face to face in Leeds with dial in facilities the group can agree to meet by teleconference where this is more convenient.

Reporting to
Joint NHS E / NHS I Workstream 3 Programme Board monthly through oral reports and papers as required.



Membership

Membership is expected to range from 10 to 15 members with an average target of 12 members the majority representing provider, commissioning and clinical perspective. The group will be quorate with 5 members present. The following is a list of identified members:

Chair

Hilary Garratt	NHS E – Deputy Chief Nursing Officer England

Task Group Chairs

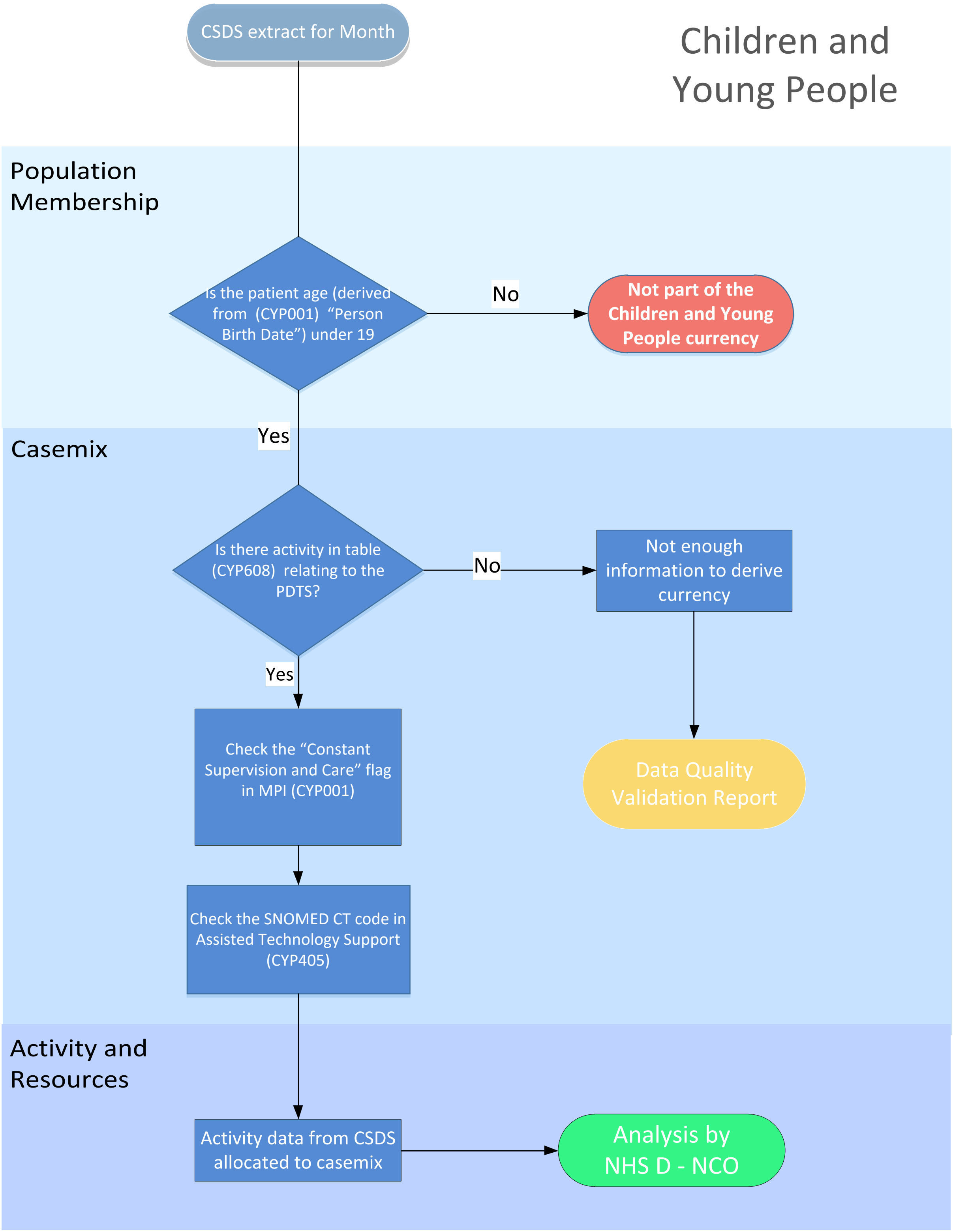
Gareth Howells	BCHFT – Exec Director Nursing & Therapies Chair of LTC TG
Claire Lemer	NHS E – ANCD CYP – Chair of CYP TG
Prof Bee Wee	NHS E – NCD EOLC – chair of EOLC TG
Shelagh Morris	NHS E – Deputy Chief AHP Office England – Chair of TI TG
Martin Vernon	NHS E – NCD OP – Chair of Frailty TG

Members

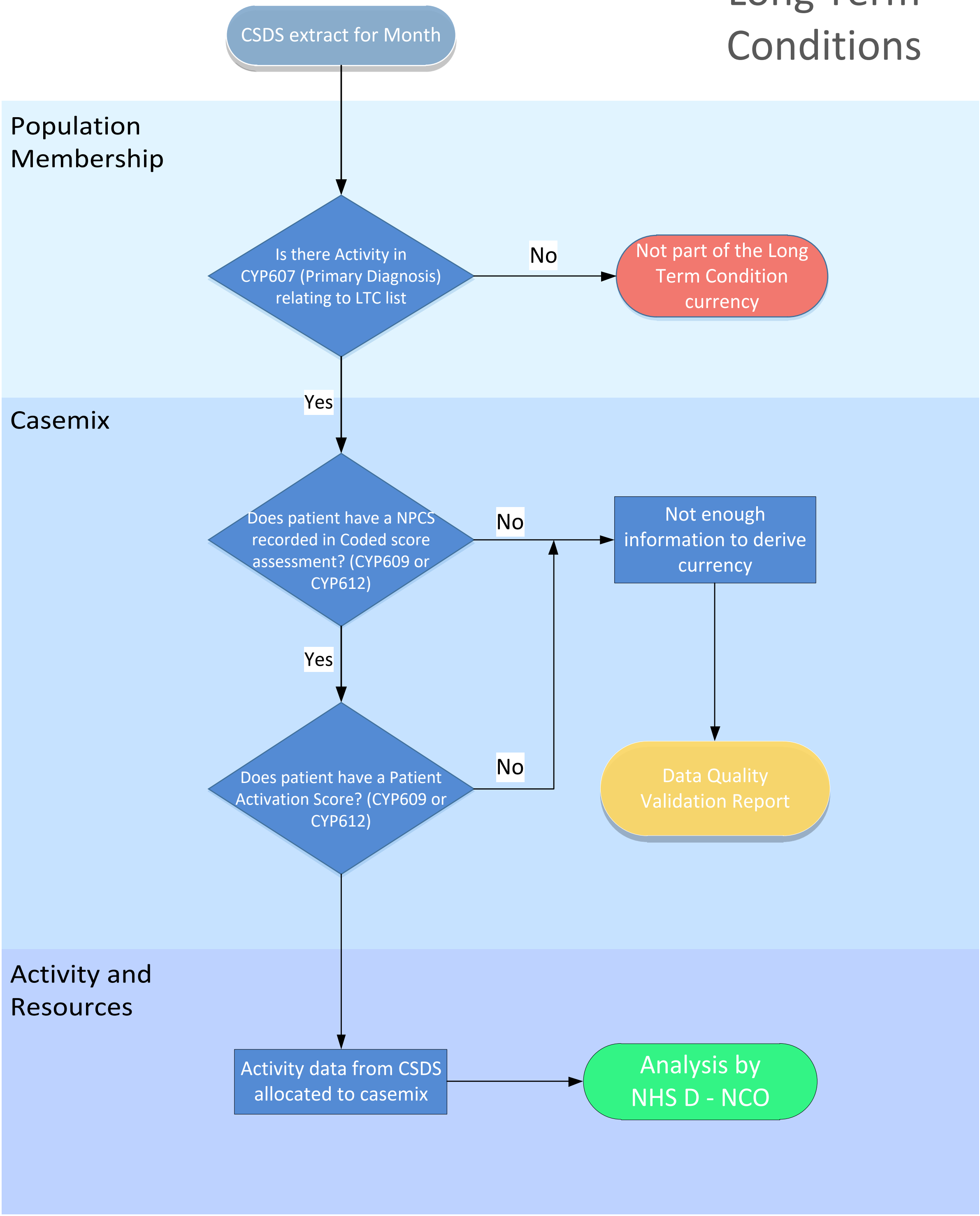
Matthew Winn	NHS Confed – Chief Executive Cambridge Community Trust
Sarah Day	HFMA – P&R Lead
Steve Wyatt	CSU EML– Head of Strategic Analytics
Kathryn Evans	NHS E – Community Nursing Lead
Michael Folan	NHS E – AHP Information Strategy Lead
Paul Beech	Bolton CCG – Director of Integration and Transformation
Nick Plummer	Kent CHT – Head of Performance
Alex Robinson	CSU AGEM – Head of Analytics
Dave Allen	NHS D – Senior Case Mix Analyst
Richard Etherington	NHS D – Case Mix Analyst
Thomas Latham	NHS D – Data Set Maintenance Operational Delivery Manager
Sue Nowak	NHS E – Head of Pricing Development
Barry James	NHS E – Pricing Development Manager Community Services
Alan Blighe	NHS E - Senior Analytical Manager
Gary Stinson	NHS E – Pricing Development Lead
David Bramley	NHS E – Deputy Head and Programme Lead - Clinical Policy Unit
Heather Caudle	NHS E – Director of Nursing – Improvement
Sue Bottomley	NHS E – Personalised Care Group - Finance Manager
Nicky Yiasoumi	NHS E – Commissioning Lead-Continuing Healthcare Strategic Improvement
Ulrich Kalternbronn	NHS I – Pricing Regulation Lead
Leslie Cove	NHS I – Pricing Policy Manager – Maternity and Community

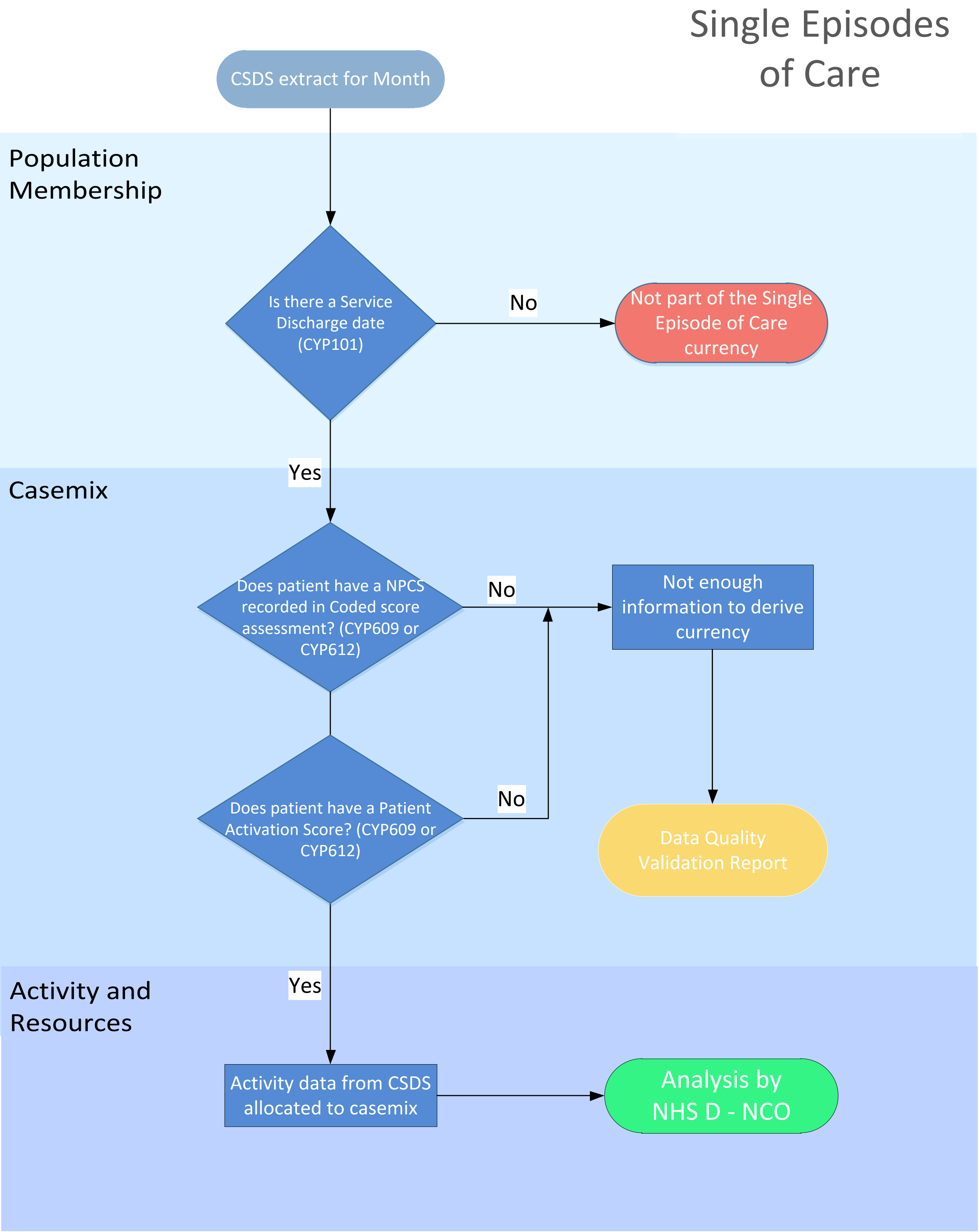
Oliva Henderson DH – Community Health Services Policy Lead

13.3 Annex C – Flow Charts for Data Submitted to the Community Services Data Set

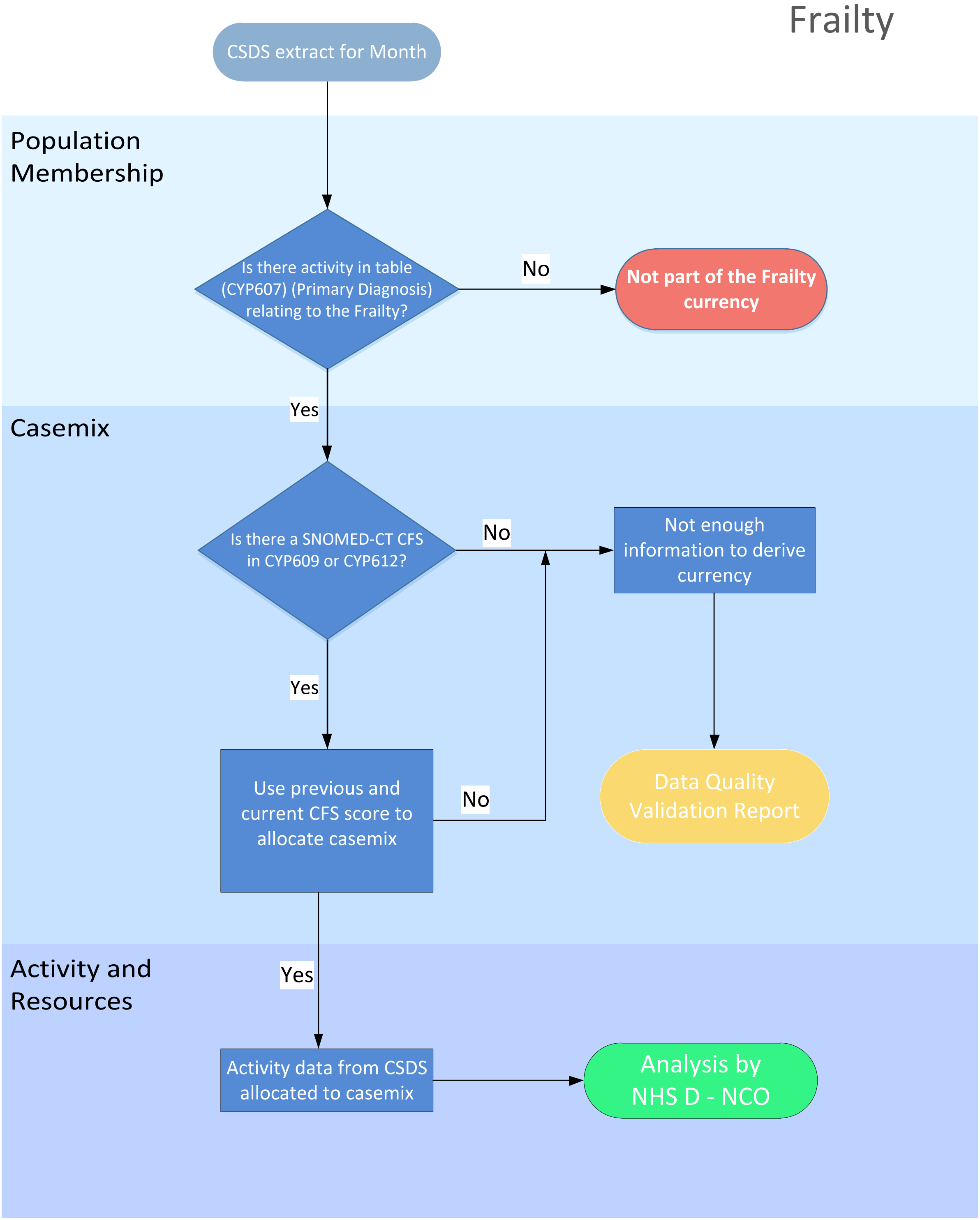


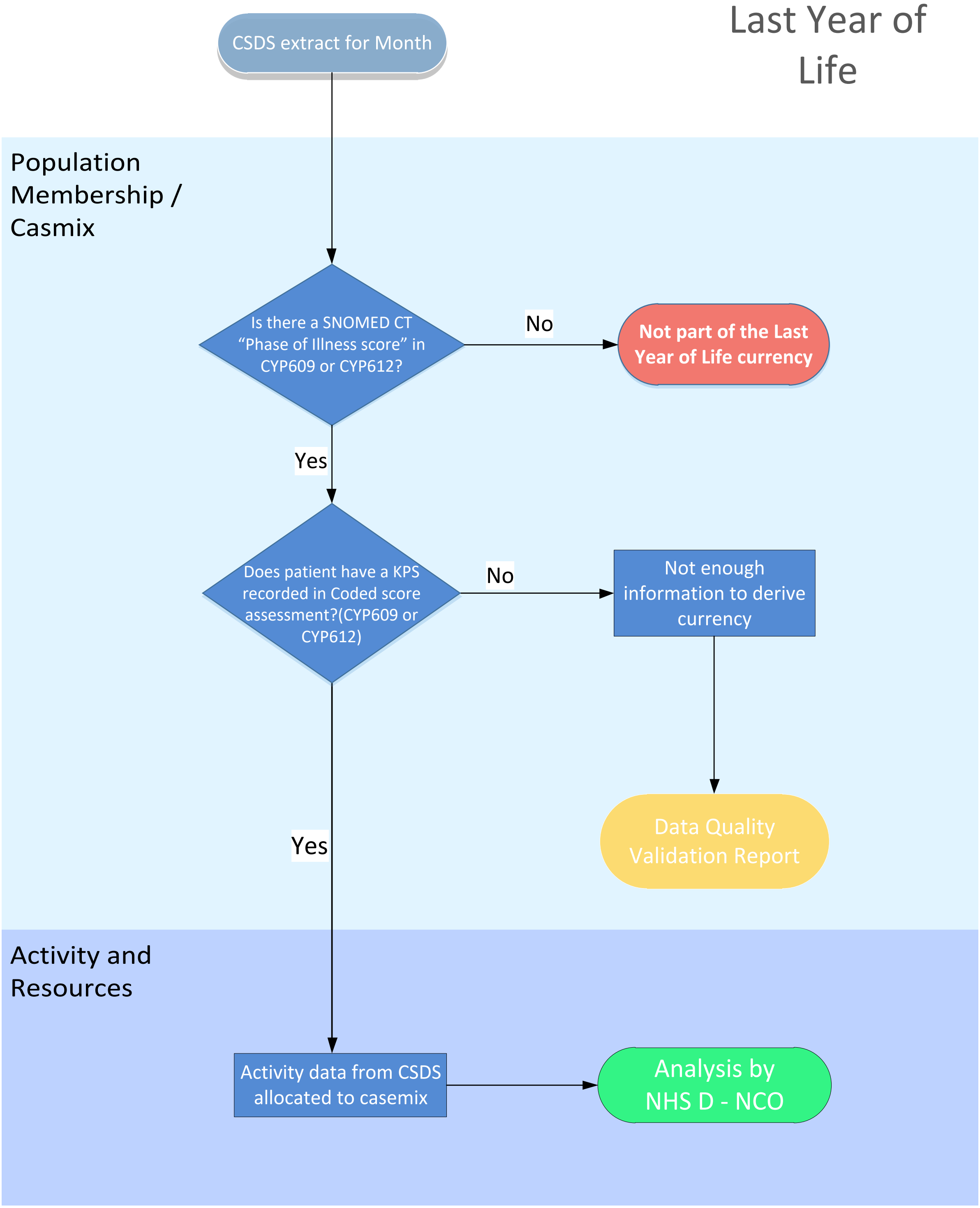
Long Term Conditions




Single Episodes of Care
CSDS extract for Month
Population Membership
Is there a Service Discharge date (CYP101)
No
Not part of the Single Episode of Care currency
Yes
Casemix
Does patient have a NPCS recorded in Coded score assessment? (CYP609 or CYP612)
No
Not enough information to derive currency
Does patient have a Patient Activation Score? (CYP609 or CYP612)
No
Data Quality Validation Report
Yes
Activity and Resources
Activity data from CSDS allocated to casemix
Analysis by NHS D - NCO

Frailty


CSDS extract for Month
Population Membership
Is there activity in table (CYP607) (Primary Diagnosis) relating to the Frailty?
No
Not part of the Frailty currency
Yes
Casemix
Is there a SNOMED-CT CFS in CYP609 or CYP612?
No
Not enough information to derive currency
Yes
Use previous and current CFS score to allocate casemix
No
Data Quality Validation Report
Activity and Resources
Yes
Activity data from CSDS allocated to casemix
Analysis by NHS D - NCO


Last Year of Life
CSDS extract for Month
Population Membership / Casmix
Is there a SNOMED CT "Phase of Illness score" in CYP609 or CYP612?
No
Not part of the Last Year of Life currency
Yes
Does patient have a KPS recorded in Coded score assessment?(CYP609 or CYP612)
No
Not enough information to derive currency
Data Quality Validation Report
Yes
Activity and Resources
Activity data from CSDS allocated to casemix
Analysis by NHS D - NCO