NHS

2020/21 National Tariff Payment System

Annex B: Guidance on currencies with national prices

November 2020

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1 Introduction

1. This document is Annex B of the 2020/21 National Tariff Payment System (2020/21 NTPS).[1] It contains further information and guidance on certain currencies for services with national prices. It should be read alongside the currency descriptions in Section 3 and Annex A of the 2020/21 NTPS. Please note: as part of the NHS response to Covid-19, during 2020/21 most providers and commissioners are using block payment arrangements, using a local variation/departure under the rules set out in Sections 6 and 7 of the NTPS. For details of the payment arrangements, see: www.england.nhs.uk/coronavirus/finance/

2. The 2020/21 NTPS introduces a blended payment for outpatient attendances (see Section 7.2 of the 2020/21 NTPS). This means that outpatient attendances are removed from the scope of national prices. As such, detailed guidance on the currencies for outpatient attendances is included in the supporting document *Guidance on blended payments*.

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

2 Diagnostic imaging

3. Separate diagnostic imaging national prices are set for services done in an outpatient setting for which there are unbundled HRGs in subchapter RD. These services are:

   a. magnetic resonance imaging scans

   b. computed tomography scans

   c. dual energy X-ray absorptiometry (DEXA) scans

   d. contrast fluoroscopy procedures

   e. non-obstetric ultrasounds

   f. nuclear medicine

   g. simple echocardiograms.

4. This excludes plain film X-rays, obstetric ultrasounds, pathology, biochemistry and any other diagnostic imaging that generates an HRG outside subchapter RD.

5. Where patient data groups to a procedure-driven HRG without a national price, the diagnostic imaging national prices apply (see below).

2.1 Where diagnostic imaging costs remain included in national prices

6. Diagnostic imaging does not attract a separate payment in the following instances:

   a. where the patient data groups to a procedure-driven HRG with a national price (that is, not from HRG4+ subchapter WF)

   b. where the national price is zero (eg LA08E, SB97Z and SC97Z, which relate only to the delivery of renal dialysis, chemotherapy or external beam radiotherapy), any diagnostic imaging is assumed to be connected to the outpatient attendance

   c. where diagnostic imaging is carried out during an admitted patient care episode or during an A&E attendance

d. where imaging is part of a price for a pathway or year of care (eg the best practice tariff for early inflammatory arthritis)

e. where imaging is part of a specified service for which a national price has not been published (eg cleft lip and palate).

7. For the avoidance of doubt, subcontracted imaging activity must be dealt with like any other subcontracted activity; that is, if provider A provides scans on behalf of provider B, provider B will pay provider A and provider B will charge its commissioner for the activity.

2.2 Processing diagnostic imaging data

8. It is expected that providers will use Secondary Uses Service (SUS)[2] submissions as the basis for payment. Where there is no existing link between the radiology system and the patient administration system (PAS), the diagnostic imaging record must be matched to any relevant outpatient attendance activity – for example, using the NHS number or other unique identifier and scan request date. This will enable identification of which radiology activity must and must not be charged for separately. Where the scan relates to outpatient activity that generates a procedure-driven HRG with a national price, the scan must be excluded from charging.

9. The Terminology Reference-data Update Distribution Service (TRUD)[3] provides a mapping between National Interim Clinical Imaging Procedure (NICIP) codes and OPCS-4 codes. NHS Digital publishes grouper documentation that sets out how these OPCS-4 codes map to HRGs.

10. Note that when using the 'code-to-group' documentation these diagnostic imaging data are subject to 'preprocessing'. This means that some of the OPCS-4 codes relating to scans do not appear on the code-to-group sheet and need to be preprocessed according to the code-to-group documentation. This process will be carried out automatically by the grouper and SUS Payment by Results (PbR). It is necessary to map the NICIP codes to OPCS-4 codes, using the TRUD mapping. In some systems it may be necessary to map local diagnostic imaging codes to the NICIP codes before mapping to OPCS-4.

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2 SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. Further detail is available at: http://digital.nhs.uk/sus

3 https://isd.hscic.gov.uk/trud3/user/guest/group/0/home

11. National clinical coding guidance, both for the OPCS-4 codes and their sequencing, must be followed. More than one HRG for diagnostic imaging will be generated where more than one scan has been done, and each HRG will attract a separate price. However, where a patient has a scan of multiple body areas under the same modality, this should be recorded using OPCS-4 codes to indicate the number of body areas and will result in one HRG that reflects the number of body areas involved. This means you would not generally expect more than one HRG for any one given modality (eg MRI) on the same day.

12. A scan will not necessarily take place on the same day as an outpatient attendance. If there is more than one outpatient attendance on the day the scan was requested, and if local systems do not allow identification of which attendance the scan was requested from, follow these steps:

    a. If the diagnostic imaging occurs on the same day as the outpatient activity, and there is more than one outpatient attendance, the scan should be assumed to be related to the activity it follows, using time to establish the order of events. If the scan occurs before any outpatient activity on that day, it should be assumed to be related to the first outpatient attendance that day.

    b. If the diagnostic imaging occurs on a different day from the outpatient activity, the scan can be assumed to be related to the first attendance on the day the scan was requested.

13. The diagnostic imaging record should be submitted to SUS PbR as part of the outpatient attendance record, and it will generate an unbundled HRG in subchapter RD. SUS PbR will not generate a price for this unbundled HRG if the core HRG is a procedure-driven HRG with a national price (that is, not from HRG4+ subchapter WF).

14. If the diagnostic imaging is not related to any other outpatient attendance activity – for example, a direct access scan or a scan post-discharge – it must be submitted to SUS PbR against a dummy outpatient attendance of TFC 812 Diagnostic Imaging. As outpatient attendances recorded against TFC 812 are zero priced, this will ensure that no price is generated for the record apart from that for the diagnostic imaging activity.

15. If there is a practical reason why it is difficult to submit the diagnostic imaging record as part of an outpatient attendance record – for example, because the scan happens after the flex-and-freeze date for SUS relevant to the outpatient attendance – we recommend a pragmatic approach. For example, the scan

could be submitted as for a direct access scan, using a dummy outpatient attendance of TFC 812 Diagnostic Imaging to ensure that no double payment is made for the outpatient attendance.

3 Chemotherapy and radiotherapy

16. This section provides information on the HRG subchapters that relate to chemotherapy and radiotherapy.

3.1 Chemotherapy delivery

17. Chemotherapy is split into two parts:

    a. a core HRG (covering the primary diagnosis or procedure) covered by national price but set at £0

    b. the unbundled HRG for chemotherapy delivery.

18. From 2020/21, the procurement HRGs are no longer currencies specified with national prices and there is no requirement to collect data on them. We are working with NHS England and NHS Improvement Specialised Commissioning to support all providers to move to pass through payments for chemotherapy drugs and treatments.

19. The majority of providers are already using the pass through approach, however there is some inconsistency in the drugs reimbursed. Therefore, Specialised Commissioning has produced a chemotherapy treatment drugs list to support the pass through reimbursement of providers from 2020/21. The list will be updated on a quarterly basis to ensure that any drugs which have been omitted and any new treatments can be added during the year. The list will exclude drugs on the NTPS high cost drug list (see Annex A, tab 13c) and those funded via the Cancer Drug Fund. Further guidance on how to raise drug queries, and the process for updating the chemotherapy treatment drug list will be produced separately by Specialised Commissioning.

20. The chemotherapy delivery HRGs are assigned for each attendance for treatment to reflect the complexity of treatment and resource use. The OPCS codes and code-to-group methodology has not changed for 2020/21. All delivery HRGs, with the exception of SB17Z (Deliver Chemotherapy for Regimens not on the National List) have a national price. The price for SB17Z will continue to be locally negotiated.

21. The cost of the delivery HRGs now includes the cost of supportive drugs listed on the NHS England and Improvement chemotherapy supportive drugs list.[4] This should support a consistent basis for reimbursement and remove the need to report costs at an individual patient level.

22. The total amount for delivery HRGs (SB11Z to SB15Z) has been increased by £29.1m in the 2020/21 NTPS. This is based on an uplift of £15 per HRG. The increase in prices is intended to be cost neutral for both providers and commissioners. Therefore, it will be necessary to undertake a quarterly reconciliation, at a provider level, between the total amount reimbursed in 2019/20 and the £15 (plus MFF) reimbursed via the 2020/21 delivery prices. Any difference should then be paid to or refunded by providers.

23. Specialised Commissioning will produce a template and set out the process for the quarterly reconciliation. The process will also set out how specific drug queries will be managed. The findings from the reconciliation will inform whether the £15 uplift needs to be amended for 2021/22 and whether the quarterly reconciliation will need to continue for all or just some providers.

Table 1: Chemotherapy delivery HRGs (not including SB11Z, oral administration)

HRG Code	Definition	Explanation
SB12Z	Deliver simple parenteral chemotherapy	Overall time of 30 minutes nurse time and 30 to 60 minutes chair time for the delivery of a complete cycle.
SB13Z	Deliver more complex parenteral chemotherapy	Overall time of 60 minutes nurse time and up to 120 minutes chair time for the delivery of a complete cycle.
SB14Z	Deliver complex chemotherapy, including prolonged infusional treatment	Overall time of 60 minutes nurse time and over two hours chair time for the delivery of a complete cycle.
SB15Z	Deliver subsequent elements of a chemotherapy cycle	Delivery of any pattern of outpatient chemotherapy regimen, other than the first attendance, for example day 8 of a day 1 and 8 regimen or days 8 and 15 of a day 1, 8 and 15 regimen.

4 www.england.nhs.uk/wp-content/uploads/2019/03/nhs-england-chemotherapy-supportive-drugs-list-v2.pdf

Table 2: Payment arrangements for chemotherapy HRGs

	Core HRG	Unbundled chemotherapy delivery HRG
Ordinary admission	eg LB35B National price includes cost of delivery	No HRG generated
Day case and outpatient	SB97Z (generated if no other activity occurs)	eg SB14Z National prices
Day case and outpatient	If other activity occurs, eg LB35B	eg SB14Z National prices
Regular day and regular night admissions	As per day case and outpatient	eg SB14Z National prices

24. The core HRG SB97Z attracts a zero (£0) price when a patient has attended solely for chemotherapy delivery. In certain circumstances it removes the need for organisations to adjust local payment arrangements for chemotherapy to take account of the core HRG for the chemotherapy diagnosis, SB97Z. These circumstances are where:

    a. chemotherapy has taken place

    b. the activity has a length of stay less than one day

    c. the core HRG which would otherwise be generated is a diagnosis-driven HRG (with no major procedures taking place).

25. Delivery codes do not include the consultation at which the patient consents to chemotherapy, nor do they cover any outpatient attendance for medical review required by any change in status of the patient. These activities would generate an outpatient HRG.

26. The reimbursement for the cost of aseptic units should continue to be negotiated locally for 2020/21.

3.2 External beam radiotherapy

27. Radiotherapy can be split into two broad areas:

    a. external beam radiotherapy

b. brachytherapy and molecular radiotherapy administration.

28. There is a national price for external beam radiotherapy.

29. The radiotherapy HRGs are similar in design to the chemotherapy HRGs in that an attendance may result in more than one HRG; that is, both preparation and treatment delivery. The national radiotherapy dataset (RTDS), introduced in 2009, must be used by all organisations providing radiotherapy services.

30. It is expected that, in line with the RTDS and clinical guidance, external beam radiotherapy treatment will be delivered in an outpatient setting. Patients do not need to be admitted to receive external beam (teletherapy) radiotherapy.

Table 4: Payment arrangements for external beam radiotherapy

	Core HRG	Unbundled radiotherapy planning HRG (one coded per course of treatment)	Unbundled radiotherapy delivery HRG
Ordinary admission	National price applies	Treat as per RTDS (radiotherapy treatment delivered as outpatient)	Treat as per RTDS (radiotherapy treatment delivered as outpatient)
Day case and outpatient	SC97Z (generated if no other activity occurs)	eg SC45Z HRG generated National prices	eg SC22Z HRG generated National prices
Regular day and regular night admissions	As per day case and outpatient	eg SC45Z HRG generated National prices	eg SC22Z HRG generated National prices

31. As in previous years, the unbundled HRG SC97Z attracts a zero (£0) price when a patient has attended solely for external beam radiotherapy. This removes the need for organisations to adjust local payment arrangements for radiotherapy to take account of the core HRG for the diagnosis. SC97Z is generated where:

a. external beam radiotherapy has taken place

b. the activity has a length of stay less than one day

c. the core HRG which would otherwise be generated is a diagnosis-driven HRG (with no major procedures taking place).

32. Planning codes do not include the consultation at which the patient consents to radiotherapy nor any outpatient attendance for medical review required by any change in status of the patient. These activities would generate an outpatient HRG.

33. Delivery codes will be assigned to each attendance for treatment (only one fraction [HRG] per attendance will attract a national price). The only exception to this rule is if two different body areas are being treated when a change in resources is identified, rather than treating a single site. Hyperfractioned radiotherapy, involving two doses delivered six hours apart, would generate two delivery attendances.

34. Preparation codes are applied to and reported on the day of the first treatment (all set out within the RTDS). Each preparation HRG in a patient episode[5] will attract a national price.

[5] For a definition of 'episode', see the NHS Data Model and Dictionary at www.datadictionary.nhs.uk/web_site_content/navigation/main_menu.asp

4 Post-discharge rehabilitation

35. The post-discharge national prices were first introduced in 2012/13 to encourage a shift of responsibility for patient care after discharge to the acute provider that treated the patient. This was in response to increasing emergency readmission rates in which many patients were being readmitted to providers after discharge.

36. There are four post-discharge national prices that must be used where a single trust provides both acute and community services. Other providers may choose to use these prices. The post-discharge prices cover four areas of care:

    a. cardiac rehabilitation

    b. pulmonary rehabilitation

    c. hip replacement rehabilitation

    d. knee replacement rehabilitation.

37. There are associated commissioning packs for cardiac rehabilitation[6] and pulmonary rehabilitation.[7]

4.1 Cardiac rehabilitation

38. Post-discharge care for patients referred to cardiac rehabilitation courses will be the responsibility of the integrated provider trust from which the patient is discharged. Any post-discharge activity for these patients during the period of rehabilitation outside a defined cardiac rehabilitation pathway will remain the funding responsibility of the patient's commissioner and is not covered by this national price.

39. The currency is based on the care pathway outlined in the commissioning pack on cardiac rehabilitation. Commissioners must pay the national price even where the provider offers a different care pathway. The provider bears the risk

[6] More information on commissioning rehabilitation services is here www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf

[7] www.gov.uk/government/publications/commissioning-toolkit-for-respiratory-services

of the patient being readmitted and it is for them to assess what type of rehabilitation is required and how it is provided.

40. Based on clinical guidance, the post-discharge price will only apply to the subset of patients identified in the commissioning pack as potentially benefiting from cardiac rehabilitation, where the evidence for the effect of cardiac rehabilitation is strongest; that is, patients discharged having had an acute spell of care for:

    a. acute myocardial infarction

    b. percutaneous coronary intervention or heart failure

    c. coronary artery bypass grafting.

41. The areas of care are characterised by the following list of spell primary diagnoses and spell dominant procedures:

    a. acute myocardial infarction: a spell primary diagnosis of I210, I211, I212, I213, I214, I219, I220, I221, I228 or I229

    b. percutaneous coronary intervention or heart failure: a spell dominant procedure of K491, K492, K493, K494, K498, K499, K501, K502, K503, K504, K508, K509, K751, K752, K753, K754, K758 or K759

    c. coronary artery bypass graft: a spell dominant procedure of K401, K402, K403, K404, K408, K409, K411, K412, K413, K414, K418, K419, K421, K422, K423, K424, K428, K429, K431, K432, K433, K434, K438, K439, K441, K442, K448, K449, K451, K452, K453, K454, K455, K456, K458, K459, K461, K462, K463, K464, K465, K468 or K469.

42. The post-discharge price is payable only for patients discharged from acute care in this defined list of diagnoses and procedures, who subsequently complete a course of cardiac rehabilitation.

4.2 Pulmonary rehabilitation

43. Post-discharge care for patients referred to pulmonary rehabilitation courses will be the responsibility of the integrated provider trust from which the patient is discharged. Any post-discharge activity outside a defined pulmonary rehabilitation pathway for these patients during the period of rehabilitation will remain the funding responsibility of the patient’s commissioner and is not covered by this price. The currency is based on the care pathway outlined in the

Department of Health commissioning pack for chronic obstructive pulmonary disease (COPD).[8] Commissioners must pay the national price even where the provider offers a different care pathway. The provider bears the risk of the patient being readmitted and it is for them to assess what type of rehabilitation is provided and how it is provided.

44. The post-discharge price will apply to patients discharged having had an acute episode of care for COPD. The national price can be paid only for patients discharged from acute care with an HRG for the spell of care of DZ65A to DZ65K, who subsequently complete a course of pulmonary rehabilitation. The commissioning pack provides detailed guidance on the evidence base for those discharged from a period of care for COPD who will benefit from pulmonary rehabilitation.

4.3 Hip replacement rehabilitation

45. Post-discharge rehabilitation care for some patients following defined primary non-trauma total hip replacement procedures will be the responsibility of the integrated provider trust from which the patient is discharged. Any post-discharge activity not directly related to rehabilitation from their surgery for these patients will remain the funding responsibility of the patient's commissioner and is not covered by this price.

46. The pathway for post-discharge activity for primary non-trauma total hip replacements, suggested by clinical leads, consists of:

    a. seven nurse/physiotherapist appointments

    b. one occupational therapy appointment

    c. two consultant-led clinic visits.

47. The national price applied therefore represents the funding for this rehabilitation pathway and will act as a maximum level of post-discharge rehabilitation payment. Local agreement will need to be reached on the price when integrated provider trusts take responsibility for post-discharge rehabilitation for patients who, after clinical evaluation, require less intensive rehabilitation pathways. The post-discharge price will fund the pathway for the first three months after discharge and does not cover long-term follow-up treatment.

[8] www.gov.uk/government/publications/commissioning-toolkit-for-respiratory-services

48. The national price can only be paid for patients discharged from acute care with an episode of care with a spell dominant procedure of W371, W381, W391, W931, W941 or W951.

4.4 Knee replacement rehabilitation

49. Post-discharge rehabilitation care for some patients following defined primary non-trauma total knee replacement procedures will be the responsibility of the integrated provider trust from which the patient is discharged. Any post-discharge activity not directly related to rehabilitation from their surgery for these patients will remain the funding responsibility of the patient's commissioner and is not covered by this price.

50. The defined clinical pathway for post-discharge activity for primary non-trauma total knee replacements, suggested by clinical leads, contains:

    a. 10 nurse/physiotherapist appointments

    b. one occupational therapy appointment

    c. consultant-led clinic visits.

51. The national price applied therefore represents the funding for this rehabilitation pathway and will be the maximum post-discharge rehabilitation payment. Local agreement will need to be reached on the price (in accordance with local pricing rules) when integrated provider trusts take responsibility for post-discharge rehabilitation for patients who, after clinical evaluation, require less intensive pathways of rehabilitation. The post-discharge price will fund the pathway for the first three months after discharge and does not cover long-term follow-up treatment.

52. The national price can be paid only for patients discharged from acute care with an episode of care with a spell dominant procedure coding of W401, W411, W421 or O181. The post-discharge currencies for hip and knee replacement cover the defined clinical pathway only for post-discharge activity.

5 Cystic fibrosis pathway payment

53. The cystic fibrosis (CF) pathway currency is a complexity-adjusted yearly banding system with seven bands of increasing patient complexity. There is no distinction between adults and children.

54. Bandings are derived from clinical information including cystic fibrosis complications and drug requirements. The bands range from Band 1, for the patients with the mildest care requirements (involving outpatient treatment two to three times a year and oral medication) to Band 5, for patients at the end stage of their illness (requiring intravenous antibiotics in excess of 113 days a year with optimum home or hospital support).

55. Patients are allocated to a band by the Cystic Fibrosis Trust using data from its national database, the UK CF Registry.[9]

56. The pathway payments cover all treatment **directly related to cystic fibrosis** for a patient during the financial year. This includes:

    a. admitted patient care and outpatient attendances (whether delivered in a specialist centre or under shared network care arrangements)

    b. home care support, including home intravenous antibiotics supervised by the CF service, home visits by the multidisciplinary team to monitor a patient's condition, eg management of totally implantable venous access devices (TIVADs), collection of mid-course aminoglycoside blood levels and general support for patient and carers

    c. intravenous antibiotics provided during inpatient spells

    d. annual review investigations.

57. For any patient admission or outpatient contact in relation to cystic fibrosis, the HRG is included in the year-of-care payment regardless of whether it is one of the CF-specific diagnosis-driven HRGs or not. All outpatient CF activity must be recorded against TFC 264 and TFC 343. Outpatient attendances as part of the CF pathway are excluded from the outpatient attendances blended payment.

[9] https://www.cysticfibrosis.org.uk/the-work-we-do/uk-cf-registry#

58. Some elements of services included in the CF pathway payments may be provided by community services and not the specialist CF centre: for example, home care support, including home intravenous antibiotics supervised by the cystic fibrosis service, home visits by the multidisciplinary team to monitor a patient's condition (eg management of TIVADs) and collection of mid-course aminoglycoside blood levels. In such cases the relevant parties will need to agree on payment from the prices paid to the specialist CF centre.

59. There some specified services that require local negotiation on price:

    a. high cost CF-specific inhaled/nebulised drugs: colistimethate sodium, tobramycin, dornase alfa, aztreonam lysine, ivacaftor and mannitol.

    b. insertion of gastrostomy devices (percutaneous endoscopic gastrostomy – PEG) and insertion of TIVADs are not included in the annual banded prices. These surgical procedures will be reimbursed via the relevant HRG price.

    c. Neonates admitted with meconium ileus who are subsequently found to have cystic fibrosis will not be subject to the cystic fibrosis pathway payment until they have been discharged after their initial surgical procedure. This surgical procedure will be reimbursed via the relevant HRG price. Once discharged after their initial surgical procedure, subsequent cystic fibrosis treatment will be covered by the cystic fibrosis pathway payment. Annual banding will not include the period they spent as an admitted patient receiving their initial surgical management.

60. Network care is a recognised model for paediatric care. This model must provide care that is of equal quality and access to full specialist centre care.

6 Looked after children health assessments

61. Looked after children[10] are one of the most vulnerable groups in society and data show that they have poorer health outcomes than other children, with a corresponding adverse impact on their life opportunities and health in later life.

62. Arrangements for commissioning and carrying out health assessments for children placed out of area can be variable, resulting in concerns over the quality and scope of assessments. To address this, a currency was devised and mandated for use in 2013/14, including a checklist for the components that must be included in the assessment.

63. The checklist tool must be completed by the health assessor and sent to the responsible commissioner or designated professional. It will be reviewed by the responsible commissioner or designated professional to support payment against the agreed quality. This checklist is set out in Table 5.

64. Mandatory national prices apply for children placed out of area. These prices are not mandatory for health assessments undertaken for children placed in area.

65. CCGs should commission providers in the area where the child has been placed to carry out the health assessments. This is because the doctor or nurse who carries out the assessment often becomes the lead professional, co-ordinating all health issues relating to that child's care. Providers in the CCG where the child has been placed will have knowledge of and be able to access any local health services required following the health assessment.

66. For more guidance on relevant roles and competences of healthcare staff see the 2015 document *Looked after children: knowledge, skills and competences of health care staff, Intercollegiate role framework*,[11] published by the Royal College of Nursing, Royal College of General Practitioners and the Royal College of Paediatrics and Child Health.

[10] www.rcpch.ac.uk/resources/looked-after-children-lac

[11] www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge__skills_and_competence_of_healthcare_staff.pdf

Table 5: Looked after children health assessment checklist tool

Child's name:			
NHS number			
Date of health assessment			
Date of request for health assessment			
Assessment completed by:			
Qualification:	Nurse	Midwife	Doctor
Competent to level 3 of the Intercollegiate Competency Framework	Yes	No	Please delete as appropriate
Section 2			
The summary report and recommendations should be typed and include: • Pre-existing health issues • Any newly identified health issues			
• Recommendations with clear timescales and identified responsible person			
• Evidence that referrals to appropriate services have been made			
• A chronology or medical history including identified risk factors			
• An up-to-date immunisation summary			
• Summary of child health screening			
• Any outstanding health appointments			
Section 3			
Child or young person's consent for assessment (where appropriate)			
Where the young person is over 16 years old written consent has been obtained for release of GP summary records, including immunisations and screening to a third party			
Evidence that the child or young person was offered the opportunity to be seen alone			
Evidence that child or young person's concerns/comments have been sought and recorded			

Child's name:			
Evidence that the carer's concerns/comments have been sought and recorded			
Evidence that information has been gathered to inform the assessment from the placing social worker and other health professionals providing care (eg child and adolescent mental health services (CAMHS), therapies, hospital services, GP)			
Is the child or young person is registered with a GP in the area?			
The child or young person is registered with a dentist or has access to dental treatment			
Date of most recent dental check or if the subject has refused this intervention			
The child or young person has been seen by an optician Date of most recent eye test or if the subject has refused this intervention			
Any developmental or learning needs have been assessed and any identified concerns documented			
Emotional, behavioural needs have been assessed and any identified concerns documented			
Lifestyle issues discussed and health promotion information given			
Recommendations have clear timescales and identified responsible person(s)			
Signed			
Dated:			

67. Please also see the following guidance:

   a. *Promoting the health and wellbeing of looked after children: revised statutory guidance*[12]

   b. *Who pays? Determining responsibility for payment to providers.*[13]

[12] www.gov.uk/government/uploads/system/uploads/attachment_data/file/276500/promoting_health_of_looked_after_children.pdf
[13] www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

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