

2017/18 and 2018/19 National Tariff Payment System

Annex E: Guidance on currencies without national prices

NHS England and NHS Improvement

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1. Introduction

1. The document provides information and guidance on currencies specified in the 2017 to 2019 National Tariff Payment System (21017/19 NTPS) that do not have national prices. It should be read alongside the relevant parts of Section 6.4 of the 2017/19 NTPS (local prices).
2. This section details the nationally specified currencies for services with no national price. These currencies should be used in local price-setting for these services, unless an alternative approach is agreed in accordance with the 2017/19 NTPS. These currencies concern:
 - a. critical care – adult and neonatal
 - b. dialysis for acute kidney injury
 - c. HIV adult outpatient services
 - d. positron emission tomography and computed tomography (PET/CT)
 - e. renal transplantation
 - f. specialist rehabilitation
 - g. ambulance services.

2. Critical care – adult and neonatal

3. Critical care is a high cost and low volume service that requires intense management and intense monitoring of the patient, using advanced nursing, therapy and medical skills. Critical care is a service that can occur in all admitted patient care and most of its activity is unplanned.
4. A critically ill patient can be defined as someone who immediately requires any form of organ support (intubation, ventilation, inotropes), or is likely to suffer acute cardiac, respiratory or neurological deterioration requiring such support.
5. The introduction of adult and neonatal critical care currencies has made it easier for providers and commissioners to agree activity and price levels.

The currency model

6. Commissioners and providers must contract for adult and neonatal critical care services using the healthcare resource group (HRG) currencies. These are based on the adult and neonatal critical care minimum datasets.
7. The HRGs for adult critical care (sub-chapter XC) have been designed using the level of support required by the patient, indicated by the number of organs supported (0 to 6).

Table 1: HRG currencies for adult critical care

HRG code	Description
XC01Z	Adult critical care - 6 organs supported
XC02Z	Adult critical care - 5 organs supported
XC03Z	Adult critical care - 4 organs supported
XC04Z	Adult critical care - 3 organs supported
XC05Z	Adult critical care - 2 organs supported
XC06Z	Adult critical care - 1 organs supported
XC07Z	Adult critical care - 0 organs supported

8. The HRGs for neonatal critical care services (sub-chapter XA) are descriptive rather than linked to a specific number of organs.

Table 2: HRG currencies for neonatal critical care

HRG code	Description
XA01Z	Neonatal critical care intensive care
XA02Z	Neonatal critical care high dependency
XA03Z	Neonatal critical care special care without external carer
XA04Z	Neonatal critical care special care with external carer
XA05Z	Neonatal critical care normal care
XA06Z	Neonatal critical care transportation

9. Due to the variation in critical care unit size, commissioners of smaller units may prefer a fixed and variable payment model to ensure capacity and availability of beds, whereas commissioners of larger units may prefer a per-patient payment model to incentivise efficiency or movement of beds to meet other strategies (eg major trauma). When adopting alternative payment approaches, providers must adhere to the general rules for local pricing and disclosure requirements in Section 6 of the 2017/19 NTPS.

3. Dialysis for acute kidney injury

10. There are four HRGs (LE01A, LE01B, LE02A and LE02B) for dialysis for acute kidney injury – these continue to be specified as the national currencies for these services. Activity for these HRGs can be identified using combinations of procedure and diagnosis codes. These HRGs are ‘unbundled’ HRGs: that is, they are generated in addition to an HRG for the core activity for the patient. One HRG will be generated for each session of dialysis.

11. We have not set a national price but a non-mandatory price will be available for haemodialysis for acute kidney injury – LE01A and LE01B. Peritoneal dialysis for acute kidney injury (LE02A and LE02B) has a national currency.

4. HIV adult outpatient services pathway currencies

12. HIV infection is a long-term chronic medical condition requiring lifelong treatment. HIV patients need accessible, consistent and effective specialist care and management of their HIV infection and any associated complications, and prevention of onward transmission.
13. The objective of the HIV outpatient pathway currency is to ensure the needs of HIV-infected people are appropriately met. In developing a year-of-care approach, the pathway takes into account ongoing changes in service delivery.

The currency model

14. The HIV outpatient currencies are a clinically designed pathway for each of three groupings of HIV adult patients (18 years and older) that supports an annual year-of-care payment approach.
15. The HIV adult outpatient currencies do not include the provision of any antiretroviral (ARV) drugs, and the currency rules apply when patients move from one provider to another.

Table 3: HIV adult outpatient currencies

HIV adult outpatient currencies
Category 1: New patients
<p>Category 1 patients are newly diagnosed in England or have newly started on ARV drugs.</p> <p>In the first year of diagnosis these patients require more intensive clinical input than stable patients. This includes a greater number of more complex diagnostic tests and more frequent clinic visits with a greater input from multidisciplinary teams.</p> <p>A newly diagnosed patient will be a Category 1 patient for one year, after which they will automatically become a Category 2 patient.</p> <p>Similarly, a patient starting ARV drugs for the first time will be a Category 1 patient for one year when they will automatically become a Category 2 patient.</p> <p>These events can immediately follow each other. For example, a patient may be newly diagnosed and then after seven months start ARV drugs. As a result, the patient would be in Category 1 for 19 months and then automatically become a Category 2 patient.</p> <p>If a patient is Category 1, but has one of the Category-3-listed complexities they become a Category 3 patient for a year.</p>
Category 2: Stable patients
<p>Category 2 covers patients that do not have one of the listed Category 3 complexities and are either not on ARV drugs or started ARV drugs more than one</p>

HIV adult outpatient currencies

year ago. This category covers most patients and therefore should be used as the default category unless Category 1 or 3 criteria can be shown and validated.

If a patient transfers to an HIV service and had started ARV drugs for the first time more than a year ago they would automatically be classified as Category 2 unless they had one of the complexities resulting in them being a Category 3 patient.

Category 3: Patients with complex needs

Patients who fall into Category 3 need high levels of maintenance, or are highly dependent patients. Complexities are:

- current tuberculosis co-infection on antituberculosis treatment
- treatment for chronic viral liver disease
- treatment for cancer
- AIDS diagnosis requiring active management in addition to ARV drugs (not inpatient care)
- HIV-related advanced end-organ disease
- persistent viraemia on treatment (more than six months on ARV drugs)
- mental illness under active consultant psychiatric care
- HIV during current pregnancy.

16. To support the currencies, Public Health England has introduced the HIV and AIDS reporting system ([HARS](#)). All organisations providing the HIV outpatient pathways must submit data to HARS. This dataset will support commissioning and epidemiology of HIV adult outpatient activity.
17. National guidance for the provision of treatment and an appropriate service specification can be found at www.bhiva.org and www.bashh.org.
18. A full explanation of the HIV outpatient clinical care pathway (version 11) can be found in the [HIV outpatient pathway guidance from the Department of Health](#).¹

5. Positron emission tomography and computed tomography (PET/CT)

19. This activity will have a national currency, set out below:

¹ <https://www.gov.uk/government/publications/hiv-outpatient-pathway-updated-guidance-available>

Table 4: PET/CT currency

RN01A	Positron emission tomography with computed tomography (PET-CT) of one area, 19 years and over
RN01B	Positron emission tomography with computed tomography (PET-CT) of one area, between 6 and 18 years
RN01C	Positron emission tomography with computed tomography (PET-CT) of one area, 5 years and under
RN02A	Positron emission tomography with computed tomography (PET-CT) of two or three areas, 19 years and over
RN02B	Positron emission tomography with computed tomography (PET-CT) of two or three areas, 18 years and under
RN03A	Positron emission tomography with computed tomography (PET-CT) of more than three areas, 19 years and over
RN03B	Positron emission tomography with computed tomography (PET-CT) of more than three areas, 18 years and under
RN07A	Positron emission tomography (PET), 19 years and over
RN07B	Positron emission tomography (PET), between 6 and 18 years
RN07C	Positron emission tomography (PET), 5 years and under
RN09Z	Myocardial positron emission tomography

6. Renal transplant

20. Kidney transplantation is the renal replacement therapy of choice for patients with chronic kidney disease stage 5 who are considered medically suitable. The patient's medical suitability is established by assessing the potential benefits of improved quality of life and longer survival relative to the risks of major surgery and chronic immunosuppression.
21. For suitable patients it is preferable to pre-emptive transplant (within six months of needing dialysis) where possible.
22. Currencies have been developed by commissioners, NHS providers, the British Transplant Society and NHS Kidney Care to support national data-recording consistency and cost convergence. The currencies are linked to all Renal Association, NHS Blood and Transplant/British Transplant Society and European best practice guidelines.

The currency model

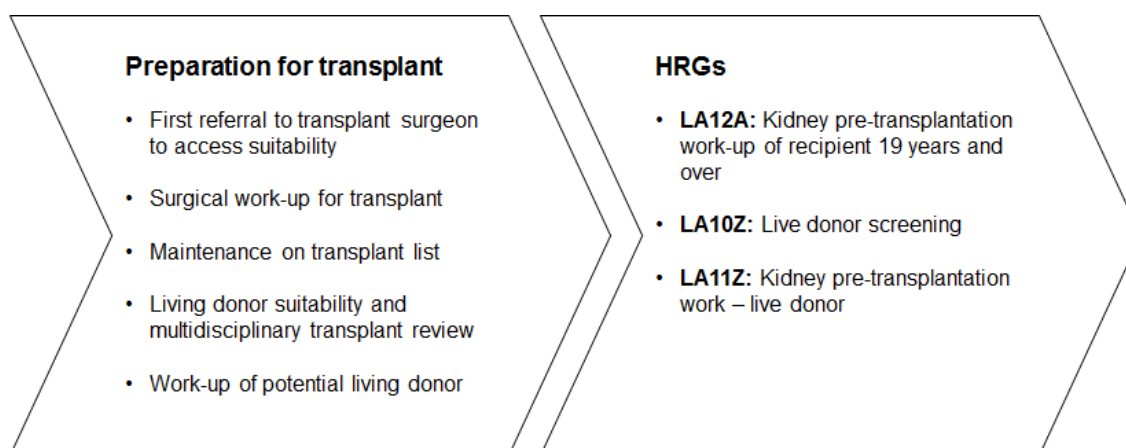
23. An adult renal transplant currency (18 years and older) uses HRGs to collect activity, and covers all care directly related to the preparation and provision of a transplant episode. This includes living donation and required post-transplant care delivered in both transplant and specialist renal centres.
24. This currency does not apply to kidney transplants with simultaneous pancreas transplants, or other multi-organ transplants incorporating a kidney transplant.

25. The currency covers activity relating to specific HRGs in use, but does not capture:
 - a. antibody-incompatible transplant
 - b. any deceased donor organ donation and costs related to the associated organ retrieval (the responsibility of NHS Blood and Transplant)
 - c. outpatient attendances where the primary purpose is to formally assess suitability for transplant.
26. This care pathway provides the opportunity to include multiple elements within the currency without incentivising multiple outpatient visits, and the ability to include elements, and in particular tissue typing, which do not easily map to an outpatient attendance.
27. The currency is made up of three components:
 - a. preparation for transplant outpatient attendances
 - b. the transplant episode including post-discharge drugs
 - c. post-transplant outpatients.

Preparation for transplantation

28. The pathway starts **after** a patient has been identified as potentially suitable for transplant and a nephrologist makes a formal outpatient referral to a transplant surgeon. The first outpatient consultation to further assess suitability for transplant with a transplant surgeon is the start of the pathway under this currency.
29. All adult pre-transplant outpatient activity related to both recipient and any potential living donor must be reported against the HRGs, each time each patient is seen in an outpatient clinic. This also includes outpatient activity while patients are on the transplant list.
30. Figure 1 shows the activities related to this component of the pathway and the HRGs to be used.

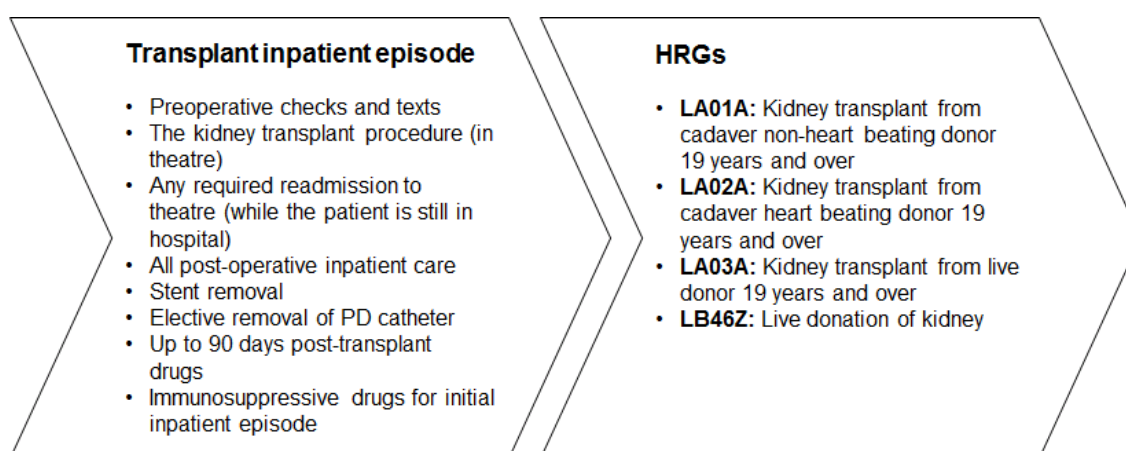
Figure 1: Preparation for transplant



Transplant inpatient episode

31. The mandatory HRGs cover all activities during the transplant episode.
32. Figure 2 shows the activities related to this component of the pathway and the HRGs to be used.

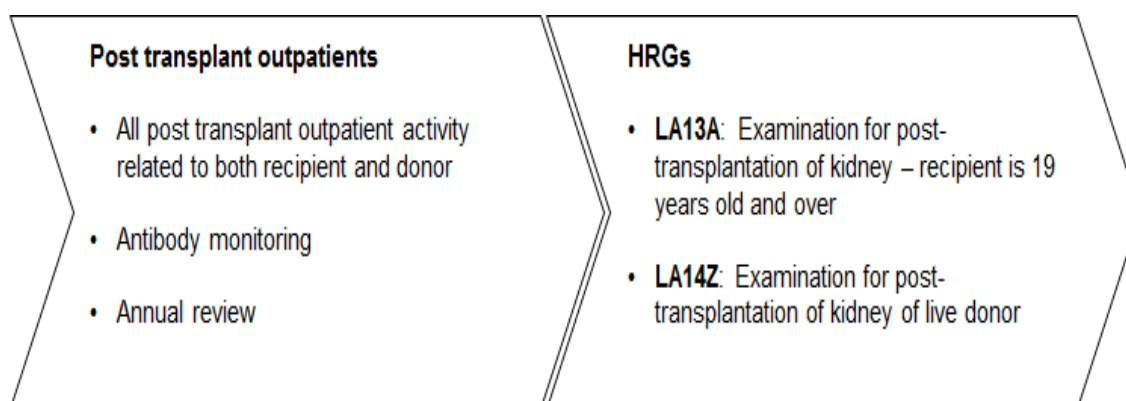
Figure 2: The transplant episode



Post-transplant outpatients

33. All adult post-transplant outpatient activity, related to both recipient and donor, must be reported against the HRG every time the patient is seen in an outpatient clinic.
34. Figure 3 shows the activities related to this component of the pathway and the HRGs to be used.

Figure 3: Post-transplant outpatient HRGs



7. Specialist rehabilitation

35. A currency model based on provider categorisation and patient need has been developed by the UK Rehabilitation Outcome Collaborative (UKROC). It aims to improve capacity, co-ordinate service provision and improve access to specialist rehabilitation services.
36. This currency is designed to give incentives for providing effective specialist rehabilitation services. It should reduce overall healthcare costs for this group of patients by supporting them in moving from an acute bed to a specialist rehabilitation service as soon as is clinically suitable. The currency model clearly designates services, so ensures that patients are treated in the right specialist rehabilitation service for their needs.
37. The non-mandatory weighted daily rate payment model has been designed to provide a fair and clearer payment approach for high cost specialised acute rehabilitation patients.

The currency model

38. The currency model was first mandated in the 2013/14 Payment by Results guidance. It designates providers into levels of specialist rehabilitation services. These service levels have different service profiles and differing costs. Patient characteristics and needs are defined using the Specialised Services National Definitions Set (SSNDS) for Rehabilitation.² The same definitions are used to inform the NHS England service specification for specialised rehabilitation for patients with highly complex needs.³

² [/www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf)

³ [/www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf)

39. The currency model only covers the admitted patient stay for people with Category A or B needs (according to the SSNDS admitted to designated adult Level 1 and 2 and children's specialist rehabilitation services).
40. The multi-level weighted bed day (WBD) has been designed for patients who will be on a specialist rehabilitation unit for six months or less. Patients for whom rehabilitation is likely to last more than six months will continue to be funded on an individual basis.
41. During the patient's admitted stay on a specialist rehabilitation unit, clinicians must use the Rehabilitation Complexity Scale (RCS-Ev12) tool to assess the patient's needs. The tool should be reapplied every two weeks for patients in Level 1 and 2a services, and at least on admission and discharge for those in Category 2b services. The combination of the type of rehabilitation unit where the patient is treated and the serially collected RCS-E score determines the currency (and locally agreed daily rate price).
42. The UKROC database provides the commissioning dataset for NHS England. All specialist rehabilitation services are required to register, and only activity reported through UKROC is eligible for commissioning under this currency. UKROC identifies the eligible activity, calculates the WBD rates and provides monthly activity reporting via the commissioning support units. It also provides quarterly reports on quality benchmarking and outcomes including cost-efficiency. Level 1 and 2a units must complete the full UKROC dataset for all case episodes that they wish to have counted as specialist rehabilitation, with fortnightly submissions to the UKROC team.
43. Level 2b services must submit their dataset at least quarterly.
44. More detailed guidance on implementation and use of the WBD currency model has been prepared through the Clinical Reference Group for Specialist Rehabilitation.⁴

Indicative reference prices

45. We note that considerable work has been undertaken with UKROC's help to update the specialist rehabilitation model with more up-to-date costing data.
46. Following sector engagement and further engagement with specialised service commissioners, we are considering the introduction of non-mandatory prices in the future but have not done so at this time.

⁴ www.csi.kcl.ac.uk/commissioning-tools.html

8. Ambulance services

47. This section details the national currencies for ambulance services. It establishes what to include and exclude when applying these currencies. Any services not specified in these lists are not subject to a national ambulance currency.
48. **Urgent and emergency care calls answered:** the unit for payment is per call.
- a. The number of emergency and urgent calls presented to switchboard and answered.
 - b. Include 999 calls, calls from other healthcare professionals requesting urgent transport for patients, calls transferred or referred from other services (such as other emergency services, 111, other third parties).
 - c. Include hoax calls, duplicate/multiple calls about the same incident, hang-ups before coding complete, caller not with patient and unable to give details, caller refusing to give details, response cancelled before coding complete.
 - d. Exclude calls abandoned before answered, patient transport services requests, calls under any private or non-NHS contract.
49. **Hear and treat/refer:** the unit of payment is per patient.
- a. A precondition of this currency is that, as a result of the call, an ambulance trust healthcare professional does not arrive on scene.
 - b. The number of incidents – following emergency or urgent calls – resolved with the patient(s) receiving clinical advice by telephone or referral to a third party.
 - c. Include patients whose call is resolved – without despatching a vehicle or where a vehicle is despatched but is called off from attending the scene before arrival – by providing advice through a clinical decision support system, or by a healthcare professional providing clinical advice, or by transferring the call to a third party healthcare provider.
50. **See and treat/refer:** the unit of payment is per incident.
- a. The number of incidents resolved with the patient(s) being treated and discharged from ambulance responsibility on scene without conveyance of the patient(s).
 - b. Include incidents where ambulance trust healthcare professionals arrive on the scene and refer (but do not convey) the patient(s) to any alternative care pathway or provider.

- c. Include incidents where, on arrival at scene, ambulance trust professionals are unable to locate a patient or incident.
 - d. Include incidents despatched by third parties (such as 111 or other emergency services) directly accessing the ambulance control despatch system.
51. **See, treat and convey:** the unit of payment is per incident.
- a. The number of incidents – following emergency or urgent calls – where at least one patient is conveyed by ambulance to an alternative healthcare provider.
 - b. Alternative healthcare provider includes any other provider that can accept ambulance patients, such as A&E, minor injuries unit, walk-in centre, major trauma centre, independent provider, etc.
 - c. Include incidents despatched by third parties (such as 111 or other emergency services) directly accessing the ambulance control despatch system.
 - d. Exclude patient transport services and other contracts with non-NHS providers.



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