2017/18 and 2018/19 National Tariff Payment System

Annex D: Guidance on currencies with national prices

NHS England and NHS Improvement

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Contents

1. Introduction

1. This document is Annex D to the 2017 to 2019 National Tariff Payment System (2017/19 NTPS). It contains further information and guidance on certain currencies for services with national prices, and should be read alongside the currency descriptions in Section 3 and Annex A to the 2017/19 NTPS.

2. The other annexes are:

Annex	Description
A	The national prices and the national tariff workbook.
B	The models used to set national prices
C	Technical guidance for mental health clusters
D	Currencies with national prices
E	Currencies with no national prices
F	Guidance on best practice tariffs

2. Outpatient care

2.1. Consultant led and non-consultant led

3. The NHS Data Model and Dictionary definition[1] of a consultant-led service is a "service where a consultant retains overall clinical responsibility for the service, care, professional team or treatment. The consultant will not necessarily be physically present for all consultant-led activity but the consultant takes clinical responsibility for each patient's care".

4. A consultant-led service does not apply to nurse consultants or physiotherapist consultants. There is no national price for non-consultant-led clinics which are subject to local price setting (in accordance with the rules on local pricing).

5. The exception to this approach is maternity services in an outpatient setting. All maternity activity, for both consultant-led care (treatment function code (TFC) 501 obstetrics) and midwife-led care (TFC 560 midwife episode), is included in the maternity pathway price.

2.2. First and follow-up attendances

6. There are separate health resource groups (HRGs) and national prices for first and follow-up attendances. A first attendance is the first or only attendance for one referral. Follow-up attendances are those that follow first attendances as

[1] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_led_service_de.asp?shownav=1

part of a series for the one referral. The series ends when the consultant does not give the patient a further appointment, or the patient has not attended for six months with no planned or expected future appointment.

7. If after discharge a new referral occurs and the patient returns to the clinic run by the same consultant, this is classified as a first attendance. The end of a financial year does not necessarily signify the end of a particular outpatient series. If two outpatient attendances for the same course of treatment are in two different financial years but less than six months apart, or the patient attends having been given a further appointment at their last attendance, the follow-up national price applies.

8. To incentivise a change in the delivery of outpatient follow-up activity, encouraging a move to more efficient models and freeing up consultant capacity, we set first attendance prices higher than those reported in reference costs and offset this by decreasing the corresponding follow-up attendance price. This transfer in cost is set at a TFC level and ranges from 10% to 30%. A full list of these TFCs is in Annex A.

9. Some clinics are organised so that a patient may be seen by a different consultant team (in the same specialty and for the same course of treatment) on subsequent follow-up visits. In this case, commissioners and providers may wish to discuss adjusting funding to recognise that some of the appointments captured in the data flow as first attendances are, as far as the patient is concerned, follow-up visits.

10. There has been some concern about levels of consultant-to-consultant referrals, and when it is appropriate for them to be paid as a first rather than follow-up attendance. Given the range of circumstances in which these may occur, it is not feasible to mandate a national approach to recording these types of attendance and their payment.

2.3. Non-face-to-face outpatient attendances

11. To incentivise a shift in activity which is targeted and clinically appropriate, we recommend non face-to-face prices are set at a treatment function code (TFC) level. In agreeing the local prices we recommend both provider and commissioner consider those TFCs where there is clear evidence that care can be delivered in an alternative way and the current pricing structure is acting as a barrier.

12. We have removed the non-mandatory non face-to-face outpatient attendance price that has been published in previous years as we feel this did not provide an appropriate incentive to move to alternative care models. Once we understand any variation in reference cost submissions and the potential

financial impact in greater detail we will consider whether to re-introduce prices for non face-to-face activity.

2.4. Multiprofessional and multidisciplinary

13. There are separate national prices for multiprofessional and single-professional outpatient attendances, which reflect service and cost differences. The multi-professional price is payable for two types of activity, with the following OPCS-4 codes:

    a. X62.2: assessment by multiprofessional team not elsewhere classified for multiprofessional consultations[2]

    b. X62.3: assessment by multidisciplinary team not elsewhere classified for multidisciplinary consultations.[3]

14. Multiprofessional attendances are defined as several care professionals (including consultants) seeing a patient together, in the same attendance, at the same time. The TFC of the consultant clinically responsible for the patient should be applied to a multiprofessional clinic where at least two consultants are present. Where there is joint responsibility between consultants this should be discussed and agreed between commissioner and provider.

15. Multidisciplinary attendances are defined as several care professionals (including consultants) seeing a patient together, in the same attendance, at the same time when two or more of the care professionals are consultants from different national main specialties.

16. The relevant OPCS code can only be applied when a patient sees two or more healthcare professionals at the same time. The clinical input of multiprofessional or multidisciplinary attendances must be reported in the clinical notes or other relevant documentation. The relevant OPCS code does not apply if one professional is supporting another, clinically or otherwise (eg by taking notes, acting as a chaperone, training, professional update purposes, operating equipment and passing instruments). Nor does it apply where a patient sees single professionals sequentially as part of the same clinic. This would count as two separate attendances and should be reported as such in line with existing NHS Data Model and Dictionary guidance on joint consultant clinics.[4]

17. The multidisciplinary attendance definition does not apply to multidisciplinary meetings (that is, when care professionals meet in the absence of the patient).

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[2] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multi-professional_consultation_(national_tariff_payment_system)_de.asp?shownav=1

[3] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multi-disciplinary_consultation_(national_tariff_payment_system)_de.asp?shownav=1

[4] http://systems.digital.nhs.uk/data/nhsdmds/faqs/cds/admitpat/consact

18. Commissioners and providers should exercise common sense in determining which attendances are multiprofessional and which are multidisciplinary, and document this appropriately in their contracts.

19. An example of a multiprofessional attendance is when an orthopaedic nurse specialist assesses a patient and a physiotherapist provides physiotherapy during the same appointment.

20. Examples of multidisciplinary attendances are:

    a. a breast surgeon and an oncologist discuss with the patient options for surgery and treatment of breast cancer

    b. a respiratory consultant, a rheumatology consultant and a nurse specialist discuss with the patient treatment for a complex multisystemic condition, eg systemic lupus erythematosus

    c. a patient (and potentially a family member) sees a paediatrician to discuss their disease and a clinical geneticist to discuss familial risk factors.

21. Examples of when the multiprofessional or multidisciplinary definitions do not apply:

    a. a consultant and a sonographer, when the sonographer is operating equipment for the consultant to view the results

    b. a maxillofacial consultant and a dental nurse passing examination instruments to the consultant

    c. a consultant and a nurse specialist, when the nurse specialist is taking a record of the consultation

    d. a consultant and a junior doctor, when the junior doctor is present for training

    e. a consultant ophthalmologist and a nurse, where the nurse administers eye drops or gives the sight exam as part of the consultation.

3. Diagnostic imaging

22. 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.

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

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

3.1. Where diagnostic imaging costs remain included in national prices

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

    a. where the patient data group 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).

26. 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 their commissioner for the activity.

3.2. Processing diagnostic imaging data

27. It is expected that providers will use Secondary Uses Service (SUS)[5] submissions as the basis for payment. Where there is no existing link between

[5] The 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

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 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.

28. The Terminology Reference-data Update Distribution Service (TRUD)[6] 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.

29. Note that when using the 'code-to-group' documentation these diagnostic imaging data are subject to 'pre-processing'. 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.

30. 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.

31. 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, these steps should be followed:

    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.

[6] https://isd.hscic.gov.uk/trud3/user/guest/group/0/home

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.

32. The diagnostic imaging record should be submitted to SUS PbR as part of the outpatient attendance record, and 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+ sub-chapter WF).

33. 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.

34. 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.

4. Maternity pathway payment system

4.1. Introduction

35. The maternity pathway payment system was mandated in April 2013 to encourage providers to focus on providing high quality, co-ordinated care.

36. Details of each phase of the pathway, casemix and how the pathway operates are provided below. The pathway system involves several different currencies and prices. For more detail see *The maternity pathway payment system – supplementary guidance*[7] which:

    a. makes clear which services are included and excluded from pathway payments

    b. gives further guidance on implementing the pathway system by establishing sufficient data flows, contracting and invoicing arrangements.

[7] www.gov.uk/government/publications/maternity-pathway-payment-system-guidance-for-nhs-providers-and-commissioners

37. The pathway payment system splits maternity care into three stages: antenatal care, delivery and postnatal care. Women may choose their provider − known as the lead provider − for each stage of the pathway. The commissioner pays the lead provider for each stage for all the pregnancy-related care a woman may need for her pregnancy, birth or postnatal care.

38. Table 1 sets out what is included and excluded from all three stages of the maternity payment system. There should be no further payments for individual elements of activity along the pathway.

Table 1: Inclusions and exclusions from the pathway payments

Area	Included	Excluded
Admitted patient care	All activity against NZ HRGs (regardless of TFC) This includes all foetal medicine, including that provided by tertiary providers[8]	All activity against non-NZ HRGs (regardless of TFC)
Outpatient care	All activity against NZ HRGs (regardless of TFC) All attendance activity against TFC 501 (obstetrics) and 560 (midwife episode) (includes all foetal medicine, including that provided by tertiary providers) Includes any activity in emergency gynaecology or early pregnancy units that codes to 'NZ' HRGs, even if before the antenatal assessment visit	All activity against non-NZ HRGs (except with a TFC of 501 or 560) An attendance TFC other than 501 or 560 Emergency gynaecology and early pregnancy activity will normally code to TFC 502 or non NZ* HRGs and will therefore be excluded
Antenatal education	Antenatal education	
Critical care		All critical care activity
Community/ primary care	All maternity community-based antenatal and postnatal care	All primary care activity applicable to payment under the GP contract. A woman may choose some of her maternity pathway to be delivered by her GP or for the practice to be the lead pathway provider, but any care delivered by the GP will be paid under the GP contract
Scans,	All maternity ultrasound scans,	The analysis elements of the

[8] Since 2014/15 foetal medicine has been coded differently, which should facilitate separate commissioning for this service in the future.

Area	Included	Excluded
screening and tests	and all relevant maternal and newborn screening which is part of national screening programmes[9]	screening process done by specialist diagnostic laboratories under a separate commissioner contract
Immunisation	All specified immunisation of the newborn which should occur before handover to primary care	
Birth	The birth, irrespective of type and setting	
Post-birth care	Well/healthy babies, both during the delivery module and pathway checks/screening during the postnatal module	Pathways for unwell/unhealthy babies. Babies requiring admitted patient care treatment will have their own admission record
Pre-pregnancy care		All pre-pregnancy/pre-conception care and reproductive services
Non-maternity care	Advice on risks in the context of pregnancy and referral to other relevant professionals where necessary for resolution if possible	All activity that is the named responsibility of other professionals or providers who receive payment to deliver that care for the population (eg drug and alcohol services, mental health services, stopping smoking services, weight management services, etc)
Specialised services	All foetal medicine, including that provided by tertiary providers	All activity paid for directly by NHS England
Ambulance transfers		All ambulance transfer costs
Accident and emergency		All unscheduled A&E activity
Clinical Negligence Scheme for Trusts (CNST)	All CNST costs are included	
High cost drugs and devices		All specified high cost drugs and devices not covered by national prices

[9] More information in NHS England *Who Pays for What?* at www.england.nhs.uk/expo/wp-content/uploads/sites/18/2015/06/who-pays-mpp-upd-06-2015.pdf

39. The next three sections set out guidance and business rules for each of the three pathway modules.

4.2. The antenatal pathway[10]

40. The antenatal pathway starts when the pregnant woman has her first antenatal appointment with her maternity provider, at around 10 weeks. It ends when the birth spell begins, or at the termination or miscarriage of the pregnancy.

41. The level of the payment the provider receives for the antenatal phase depends on the assessment at the first antenatal appointment and associated tests. From this assessment, women are assigned to one of three casemix levels: standard, intermediate or intensive based on their existing characteristics (factors).

42. The characteristics (factors) that determine casemix level and payment are in Annex B1 under maternity data requirements and definitions. A woman may have multiple factors during the antenatal phase. In general, the following allocation rules apply:

    a. if a woman has one or more of the 'intensive resource' characteristics, she is allocated to the intensive pathway, irrespective of any other factors

    b. if a woman does not have any of the intensive resource characteristics but has any one (or more) of the intermediate resource characteristics, she is allocated to the intermediate pathway

    c. if a woman does not have any of the listed characteristics, she is allocated to the standard resource pathway.

Change in casemix level during antenatal phase

43. Some women develop complications during the pregnancy (or complications might be disclosed after the antenatal assessment appointment) that require higher levels of care than initially determined. The standard pathway price has been developed to take into account the change in casemix levels of a proportion of women.

Pregnancies that end early

44. The antenatal payment is payable for all pregnancies that involve an antenatal assessment, regardless of when the pregnancy ends. The cost of

[10] Any activity that takes place before the first antenatal appointment in an emergency gynaecology or early pregnancy unit, and which codes to an NZ HRG, is included in the antenatal pathway and should not be invoiced separately from the pathway payment.

obstetric/maternity-related healthcare activities (with an NZ* HRG or coded to TFC 501 or 560) for pregnant women whose pregnancy ends before the antenatal assessment must not be paid separately. In some cases of termination or miscarriage, depending on the healthcare requirements of the woman, a birth payment and/or a postnatal pathway payment may still be warranted.

45. Contracts must contain local outcomes and quality measures to incentivise reducing the number of avoidable pregnancy losses.

46. Supplementary guidance has been published here[11] in response to queries about whether certain activities that take place in emergency gynaecology or early pregnancy units are included or excluded from the maternity pathway.

Antenatal care spanning more than one financial year

47. Care delivered under the pathway payment system may span more than one financial year. Guidance[12] on how to apportion costs was agreed some years ago between NHS England, Monitor, the NHS Trust Development Authority, the Audit Commission and the Department of Health.

48. Further guidance has been published on the contractual relationship between the providers and information flows in the supplementary guidance.[13]

4.3. The delivery pathway

49. The delivery pathway begins at the birth spell and includes all postpartum care of women and their babies (unless the babies have identified health problems) until they are transferred to community postnatal care.

50. There are two delivery pathway prices, depending on whether or not there were complications and comorbidities (CC) during the delivery phase. CCs for the delivery phase are based on ICD diagnosis codes and listed in the NHS Digital grouper documentation.[14] These prices also take into account the higher-cost types of births, such as caesarean sections. Current national average proportions for with and without complications and comorbidities in the model are:

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11 www.gov.uk/government/uploads/system/uploads/attachment_data/file/342522/maternity_payment_pathway_system_supplementary_guidance.pdf

12 www.doh.gov.uk/doh/finman.nsf/526655e250fd75150025673e0036b174/3d7024ca063e35ef80257c9b005c066b/$FILE/Maternity%20pathways%20accounting%20140314.pdf

13 www.gov.uk/government/publications/maternity-pathway-payment-system-guidance-for-nhs-providers-and-commissioners

14 http://digital.nhs.uk/casemix/downloads

a. with CCs: 63 %

b. without CCs: 37%.

Providers should continue to code their delivery spells as they currently do and payment will continue to be through SUS PbR to the organisation that reports the birth.

51. Commissioners will only pay once per intrapartum episode, to the organisation that delivers the baby or babies. This organisation is the lead provider financially responsible for the whole postpartum care period up to transfer of responsibility to domiciliary postnatal care. Where more than one provider shares the care (eg the woman delivers at one provider and another provides postpartum in-hospital care), it is the responsibility of the providers to agree a fair split of the income.

52. Home births continue to be collected in the admitted patient care other delivery event commissioning dataset (CDS) and are paid at the same rate as a normal delivery without complications. All pathway providers must be able to provide all care, either themselves or with their partner organisations/in their network.

53. Additional ‘per day’ payments will apply for patients who stay longer than pre-set durations (known as trim points).

4.4. The postnatal pathway

54. The postnatal pathway begins after the woman and baby or babies have been transferred to community postnatal care, and ends after they have transferred to primary care or a health visitor.

55. This pathway follows the same format as the antenatal pathway, with three levels of casemix depending on the expected resource use − standard, intermediate or intensive. The level will usually be assigned when a patient is discharged after the intrapartum episode based on her specific health and on social care characteristics collected at the antenatal booking appointment. It may be supplemented with information gathered over the previous stages of the maternity.

56. Similar to the other phases, a commissioner will make one payment for all postnatal pathway care included in the scope, regardless of the care setting. When a woman chooses to use a different provider for an element of her postnatal care (an investigation, spell or appointment, etc) or is referred to a different provider for any reason, it is the responsibility of the lead pathway provider to pay the other organisation.

57. All postnatal care, as defined in NICE clinical guideline 37[15] *Postnatal care: routine postnatal care of women and their babies*, including the six-week postnatal care review if undertaken by the maternity team, is included in pathway payments, even if maternity healthcare has already been transferred to primary care or the health visitor. There is no defined time period during which community postnatal care is provided by the maternity team.

58. There are some specific exceptions, which should be paid based on the relevant HRGs. NICE guidance identifies the following potential postnatal complications that require immediate urgent acute care, where payment must be claimed from local commissioners:

    a. intervention for postpartum haemorrhage

    b. intervention for genital tract sepsis

    c. intervention for venous thromboembolism

    d. intervention for breast mastitis, abscess

    e. postnatal wound infection requiring surgery

    f. pulmonary embolism.

59. The costs for these complications, if they happen before discharge from hospital after the birth, are included in the birth payment. In these circumstances, providers are not able to claim payment for these interventions instead of, or in addition to, the birth payment.

60. Commissioners and providers should determine whether there are any activities during the maternity pathway that could help to reduce the incidence of such complications, or whether any local policies contribute to the incidence of complications. Commissioning for Quality and Innovation (CQUIN) or Quality, Innovation, Productivity and Prevention (QIPP) programme indicators could be developed locally.

61. Commissioners should introduce local outcome and patient experience indicators to ensure high quality care and that the timing for handover of responsibility is safe.

4.4.1. Arrangements between providers

62. A woman may receive some of her care from a provider other than her lead provider because of choice or clinical reasons. In this case, the lead provider who has received payment from a commissioner must pay the other

[15] www.nice.org.uk/guidance/cg37

organisation. This payment mechanism also applies if she needs care from another NHS provider while she is on holiday or unable to access her pathway provider.

63. Further guidance[16] has been published on the nature of the arrangements between the providers and on information flows.

64. Prices must be agreed between the two providers. For some activity, non-mandatory guideline prices are provided in the *National tariff information workbook*, to provide guidance on the amounts to be paid and invoiced between providers. Providers must not attempt to invoice local commissioners for NZ* HRGs or TFC 501/560 activity or elements of maternity care costs.[17] If they are not the lead provider for the activity, they can use local data flows and the help of commissioning support units or Data Services for Commissioners Regional Offices to establish who is the lead provider and invoice them.

65. In certain cases, a women may change her lead provider. This should lead to a transfer of funding between the two providers. The proportion of the pathway payment remaining unspent at the time of transfer depends on the stage of pregnancy the woman has reached (see Table 2). This information was developed through analysis of the pathway costing data provided by NHS trusts and foundation trusts during spring and summer 2011. Any local change of lead provider arrangements will not alter the maternity information system and organisations may need to agree supplementary information flows when this happens.

Table 2: Proportion of pathway price to refund or transfer on change of pathway provider

Transfer time (gestational age)	Refund by lead provider A to commissioner A/ Payment to lead provider B by commissioner B/ Payment by lead provider A to lead provider B
Before 20 weeks 0 days	63%
Between 20 weeks 0 days and 24 weeks 6 days	48%
Between 25 weeks 0 days and 30 weeks 6 days	33%
Between 31 weeks 0 days and 35 weeks 6 days	20%
After 36 weeks 0 days	10%

[16] /www.gov.uk/government/publications/maternity-pathway-payment-system-guidance-for-nhs-providers-and-commissioners

[17] NZ* denotes any HRG beginning with the code NZ.

66. The other provider may choose to reassess the woman's pathway at the time of transfer. If the new information suggests that a higher resource pathway would be applicable, the pro-rata payment must be based on the value of the higher resources pathway.

67. When a woman changes both commissioner and provider (eg if she moves house), any refunds to the original commissioner (by the original lead provider) are based on the original categorisation at the antenatal assessment appointment, (so if the original pathway was standard, the proportion of refund is based on the standard payment price). The payment by the new commissioner to the new lead provider, however, will be based on the latest information and may be a proportion of the higher resource pathway. Examples are provided in Table 3 below to aid understanding of this issue.

Table 3: Examples of transfer scenarios

Action / Activity	Consequence
Example 1	
Woman categorised as standard care based on antenatal assessment appointment information	Payment of eg £1,200 [18] for standard antenatal care by commissioner A to provider A after antenatal assessment appointment
Woman develops gestational diabetes week 23	Onset of gestational diabetes (one of the intensive factors)
Woman moves lead provider in week 29, no change in commissioner	Change in provider
Payment transfer	Lead provider A pays 33% of Intensive price (eg £3,000 * 33% = £1,000) to lead provider B
Example 2	
Woman categorised as standard care based on antenatal assessment visit information	Payment of eg £1,200 for standard antenatal care by commissioner A to provider A after antenatal assessment appointment
Woman develops gestational diabetes week 23	Onset of gestational diabetes (diabetes is one of the Intensive factors)
Woman moves house in week 29, new provider and new commissioner	Change in commissioner and provider
Refund	Provider A refunds 33% of standard payment of £1,200 to commissioner A = £400
New payment	Payment of 33% of Intensive payment (eg £3,000 * 33% = £1,000) from commissioner B to

[18] Not actual price.

Action / Activity	Consequence	
	provider B	

4.5. Information flows for the antenatal and postnatal pathways

68. The Maternity Services Data Set (MSDS) has been collecting data since April 2015. In addition, commissioners and providers have been using local information flows for the supplementary data required for the antenatal and postnatal pathway modules. For further information on data definitions and requirements see Annex A (maternity data requirements and definitions) and the maternity supplementary guidance.

69. Unlike SUS+, the system for the collection of MSDS does not have an annual refresh submission option. Instead, organisations make a 'pre-deadline' submission once an expected delivery date is known. The window between the reporting period for the activity and the submission deadline is 12 weeks. For example, activity data for April are reported in May and the submission window remains open until July. During this two to three month submission window, organisations can refresh the data by providing more information in successive submissions while the window for those reporting periods is still open.

70. Once the deadline for the reporting period is reached, the submission window is closed and the 'last good submission file' is processed for reporting. The woman's pathway will be determined from this data and the supplementary data from local information flows.

71. Commissioners will be able to access full data extracts that show activity and lead provider information for each woman contained in a provider's submission file. The reports will also enable lead providers to view information submitted by other providers; for example, where a woman 'double-books' or receives elements of care from another provider. This will help providers to discuss and agree cross-provider charging arrangements outside the system.

72. As the MSDS is new, details of previous obstetric history will not be available via the national dataset for the first few years of operation. Some of this information is required to determine the correct level of payment for the current pregnancy so commissioners and providers will need to agree temporary local information flows for these extra data items to ensure appropriate payments.

73. HIV-positive (HIV+) status also affects the level of payment providers receive. To meet a legal requirement that protects the identity of patients who are HIV+, data relating to HIV and other sexually transmitted infections are held anonymously in the MSDS and not linked to the woman's record. The MSDS extract identifies the number of women for whom HIV status will result in a move

from the standard or intermediate pathways to the intensive pathway so that contract payments can be adjusted.

5. Chemotherapy and radiotherapy

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

5.1. Chemotherapy delivery

75. Chemotherapy is split into three parts:

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

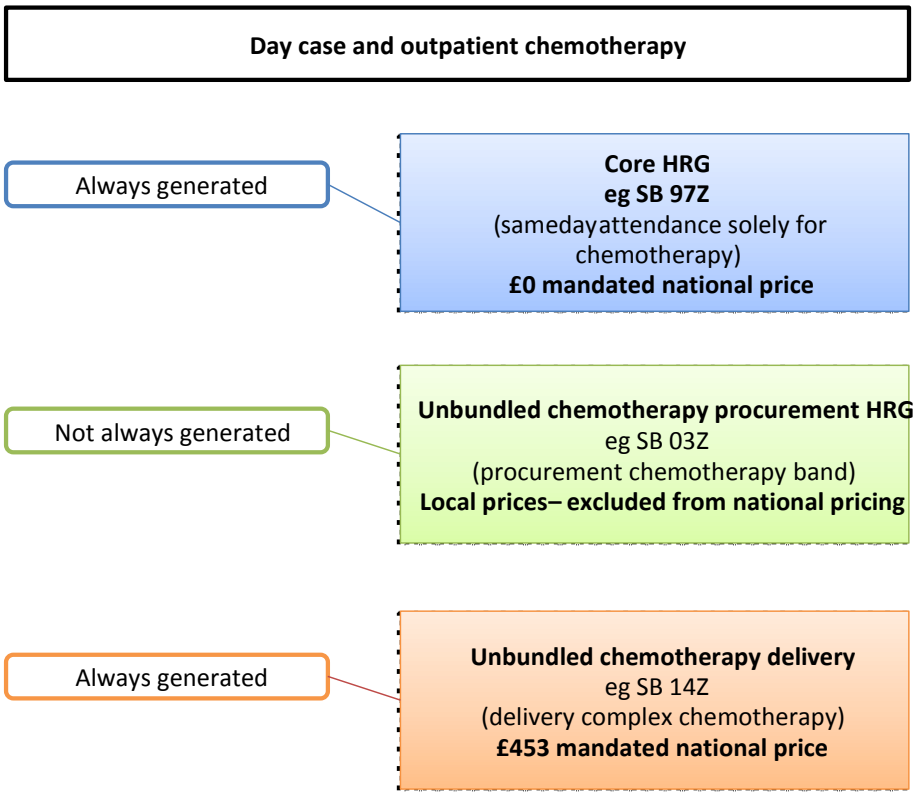
    b. the unbundled HRG for chemotherapy drug procurement

    c. the unbundled HRG for chemotherapy delivery.

76. The procurement element of chemotherapy remains subject to local prices.

77. This is illustrated in Figure 1.

Figure 1. Chemotherapy HRGs



78. The procurement HRGs are for the procurement of chemotherapy drugs for regimens split into bands. There are currently 10 cost bands covering adult and paediatric regimens.

79. The costs of each of the procurement HRGs contain all costs associated with procuring each drug cycle, including supportive drugs and pharmacy costs (indirect and overheads).

80. The chemotherapy delivery HRGs are assigned for each attendance for treatment to reflect the complexity of treatment and resource use.

Table 4: Chemotherapy delivery HRGs (not including oral administration)

Definition	Explanation
Deliver simple parenteral chemotherapy	Overall time of 30 minutes nurse time and 30-60 minutes chair time for the delivery of a complete cycle.
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.
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.
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.

Table 5: Payment arrangements for chemotherapy HRGs

	Core HRG	Unbundled chemotherapy procurement HRG	Unbundled chemotherapy delivery HRG
Ordinary admission	eg LB35B National price includes cost of delivery	eg SB03Z HRG generated – excluded from national price. Local prices agreed	No HRG generated
Day case and outpatient	SB97Z (generated if no other activity occurs)	eg SB03Z HRG generated – excluded from national price. Local prices agreed	eg SB14Z National prices

	Core HRG	Unbundled chemotherapy procurement HRG	Unbundled chemotherapy delivery HRG
Day case and outpatient	If other activity occurs, eg LB35B	eg SB03Z HRG generated – excluded from national price. Local prices agreed	eg SB14Z National prices
Regular day and regular night admissions	As per day case and outpatient	eg SB03Z HRG generated – excluded from national price. Local prices agreed	eg SB14Z National prices

81. The core HRG SB97Z attracts a zero (£0) price when a patient has attended solely for chemotherapy delivery and in certain circumstances it removes the need for organisations to adjust local payment arrangements for chemotherapy to take into account 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).

82. 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.

83. For non-oral chemotherapy regimens not on the national regimen list, the delivery HRG SB17Z must be negotiated locally as, by the nature of new regimens and potentially differential delivery methods, the costs will vary. Oral chemotherapy regimens must be paid for under SB11Z regardless of whether the regimen is included on the national regimen list.

84. Specified drugs that are not covered by national prices when used for chemotherapy may also be prescribed for other indications. When used for non-chemotherapy indications they may or may not continue to be specified. For example, rituximab is listed on both the regimens list and the specified high cost drugs list.

Table 6: Treatment of hormonal therapies and high cost supportive drugs

Method of delivery	Hormone treatments	Supportive drugs
As an intrinsic part of a regimen	If included within a regimen, ignore	If included within a regimen, ignore
By itself	Code to the relevant admission/outpatient attendance/procedure core HRG generated (not chemotherapy specific)	Apportion over procurement bands, potentially extra delivery time/costs
As part of supportive drug	Include costs within drug costs	N/A

85. If a hormone treatment is not used as an intrinsic part of a regimen, or as a supportive drug to a regimen, it is covered by national prices unless it appears on the specified high cost drugs list or when it is included in a British National Formulary section or subsection that is wholly excluded from prices.

5.2. External beam radiotherapy

86. Radiotherapy can be split into two broad areas:

    a. external beam radiotherapy

    b. brachytherapy and molecular radiotherapy administration.

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

88. 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.

89. 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 7: 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)

	Core HRG	Unbundled radiotherapy planning HRG (one coded per course of treatment)	Unbundled radiotherapy delivery HRG
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

90. 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 into account 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).

91. 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.

92. 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.

93. 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[19] will attract a national price.

6. Post-discharge rehabilitation

94. 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.

95. 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.

96. There are associated commissioning packs for cardiac rehabilitation[20] and pulmonary rehabilitation.[21]

6.1. Cardiac rehabilitation

97. 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.

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

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

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

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

99. 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.

100. 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.

101. 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.

6.2. Pulmonary rehabilitation

102. 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).[22] Commissioners must pay the national price even where the provider offers a different care pathway. The provider bears the risk of the

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

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

103. 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.

6.3. Hip replacement rehabilitation

104. 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.

105. 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.

106. 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.

107. 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.

6.4. Knee replacement rehabilitation

108. 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.

109. 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.

110. 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.

111. 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.

7. Cystic fibrosis pathway payment

112. 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.

113. Bandings are derived from clinical information including cystic fibrosis complications and drug requirements. The bands range from band one, for the patients with the mildest care requirements (involving outpatient treatment two to three times a year and oral medication) to band five, 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).

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

115. 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 in-patient spells

d. annual review investigations.

116. 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.

117. 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.

118. 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.

119. 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. Looked after children health assessments

120. Looked after children[23] 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.

121. 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.

122. 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 8.

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

124. 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.

125. For more guidance on relevant roles and competences of healthcare staff *see Looked after children: knowledge, skills and competences of health care staff, Intercollegiate role framework*[24] published by the Royal College of Nursing and the Royal College of Paediatrics and Child Health in May 2012.

[23] www.rcpch.ac.uk/child-health/standards-care/child-protection/looked-after-children/looked-after-children

[24] www.rcn.org.uk/__data/assets/pdf_file/0019/451342/RCN_and_RCPCH_LAC_competences_v1.0_WEB_Final.pdf

Table 8: 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 time scales 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			
Evidence that the carer's concerns/comments have			

Child's name:			
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	y		
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.	y		
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 time scales and identified responsible person(s)			
Signed			
Dated:			

126. Please also see the following guidance:

a. *Promoting the health and wellbeing of looked after children: revised statutory guidance*[25]

b. *Who pays? Determining responsibility for payment to providers*.[26]

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

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