2021/22 National Tariff Payment System

Annex B: Guidance on currencies

September 2021

Contents

1 Introduction

1. This document is Annex B of the 2021/22 National Tariff Payment System (2021/22 NTPS). It should be read alongside the currency descriptions in Section 5 and Annex A of the 2021/22 NTPS.

2. The 2021/22 NTPS introduces an aligned payment and incentive model for almost all secondary care services (see Section 3 of the 2021/22 NTPS). This involves a significant reduction in the scope of national prices, which would apply to unbundled diagnostic imaging services only.

3. We have continued to calculate unit prices for all services that had national prices in the 2017/19 NTPS (before the introduction of blended payment in 2019/20). These unit prices are available to support local pricing where the aligned payment and incentive approach does not apply (for example, for contracts between providers and commissioners in different ICSs, with a value of less than £10 million).

4. The 2012 Health and Social Care Act allows national tariff rules which require that, where a national currency is specified for a service which does not have a national price, it must be used as the basis for local price-setting. The rules for the aligned payment and incentive approach involve a currency consisting of the services within the scope of the payment, as provided by an individual provider during the financial year. This currency must be used as the basis for the single annual payment. In previous years, the national tariff local pricing rules specified other mandatory currencies (eg for mental health and ambulance services). For 2021/22, those mandatory currencies are not retained, although other requirements of the rules remain in place. For activity where neither the national prices nor the aligned payment and incentive approach apply, commissioners and providers may (but are not obliged by the rules to) continue to use an activity-based payment approach. Such an approach may use the unit prices set using the currencies explained below, and/or payment approaches based on other currencies, such as mental health clusters, applicable to services without unit prices.

5. The individual currencies therefore continue to have a role in local pricing, and this document contains further information and guidance on the currencies used to set these unit prices (Sections 2-10) and some currencies with neither national prices or unit prices (Sections 11-19). Some of these currencies in the

latter sections do have ‘non-mandatory guide prices’. Previously, these were published as non-mandatory prices which could be used by commissioners and providers where no national price applied. With the shift from national prices to unit prices, the guide prices are retained as a separate category, although both these and unit prices are non-mandatory.

2 Admitted patient care

6. Spell-based HRG4+ phase 3 is the currency design for admitted patient care (excluding emergency care and maternity services). A spell covers the period from admission to discharge. If a patient is under the care of one consultant for their entire spell, this would comprise one finished consultant episode (FCE). Occasionally, a patient will be under the care of more than one consultant during their spell; this would mean that a single spell had multiple FCEs.

7. When a patient has more than one distinct admission on the same day[1] (eg the patient is admitted in the morning, discharged, then readmitted in the afternoon), each admission is counted as the beginning of a separate spell.

8. Unit prices for admitted patient care cover the care received by a patient during their spell in hospital, including the costs of services such as diagnostic imaging.

9. The costs of some elements of the care pathway, such as critical care and high cost drugs, are excluded from unit prices. Local prices should be agreed for these services using the general local pricing rules in Section 4 of the 2021/22 NTPS.

10. To promote movement to day-case settings where appropriate, most prices for elective care are for the average of day-case and ordinary elective care costs, weighted according to the proportion of activity in each group.

11. For a few HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. This is done where it is clinically appropriate to have a price that is independent of setting.

12. Long-stay payments apply to admitted patient care. These are explained in detail below.

13. In previous tariffs, short stay emergency (SSEM) adjustments used to apply to national currencies and national prices for admitted patient care. However, SSEM adjustments would now be applied where unit prices are used. See Annex A, tab 8 for details.

[1] Calendar day, not 24-hour period

Long-stay payment

14. For patients who remain in hospital beyond an expected length of stay for clinical reasons, there is a reimbursement in addition to the unit price called a ‘long-stay payment’ (sometimes referred to as an ‘excess bed day payment’). The long-stay payment applies at a daily rate where the length of stay of the spell exceeds a ‘trim point’ specific to the HRG.

15. A long-stay payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a specified trim point[2] specific to the HRG and point of delivery.

16. The trim point is defined in the same way as for reference costs, but is spell based and there are separate elective and non-elective trim points. The trim point for each HRG is shown alongside unit prices in Annex A, tab 1.

17. For 2021/22, there is a trim point floor of five days.[3] There are two long-stay payment rates per chapter – one for child-specific HRGs and one for all other HRGs.

18. If a patient is medically ready for discharge and delayed discharge payments have been imposed on local authorities under the provisions of the Community Care (Delayed Discharges etc) Act 2003, commissioners should not be liable for any further long-stay payment.

19. Long-stay payments should only be adjusted when SUS+ applies an adjustment for delayed discharge when the Discharge Ready Date field is submitted in the Commissioning Data Set, by removing the number of days between the ready date and actual discharge date from any long-stay payment. Where the Discharge Ready Date field is submitted, providers will wish to satisfy themselves that local authorities are being appropriately charged.

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2 The trim point is defined as the upper quartile length of stay for the HRG plus 1.5 times the inter-quartile range of length of stay.

3 For simplicity, there is a trim point floor of at least five days for all HRGs in Annex A, regardless of whether the HRG includes length of stay logic of less than five days.

3 Outpatient attendances

20. Outpatient attendance activity is based on groupings that relate to clinical specialty, defined by treatment function code (TFC),[4] attendance type (first or follow-up attendance, face-to-face or non-face-to-face), and single professional or multiprofessional clinics.

21. Separate unit prices are set based on:

- clinic type, categorised according to treatment function code (TFC)
- consultant-led or non-consultant-led
- first or follow-up attendances
- single professional or multiprofessional clinic
- face-to-face or non-face-to-face

3.1 Consultant-led and non-consultant led

22. The NHS Data Model and Dictionary definition[5] 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".

23. A consultant-led service does not apply to nurse consultants or physiotherapist consultants.

3.2 First and follow-up attendances

24. There are separate healthcare resource groups (HRGs) for first and follow-up attendances, derived from the information recorded in "First attendance". A first attendance is the first or only attendance for one referral. Follow-up attendances are those that follow first attendances as 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.

[4] TFCs are defined in the NHS Data Model and Dictionary as codes for 'a division of clinical work based on main specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including consultants'.

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

25. 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 price applies.

26. To incentivise a change in the delivery of outpatient follow-up activity, encouraging a move to more efficient models and freeing 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 (frontloading) is set at a TFC level and ranges from 10% to 30%. A full list of these TFCs is in Annex A.

27. For those that want to use prices without frontloading, as more cost-reflective prices, we have calculated a set of non-frontloaded benchmark prices for guidance. These are published in the *Non-mandatory guide prices* workbook.

28. 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.

29. 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 specify a national approach to recording these types of attendance and their payment.

3.3 Multiprofessional and multidisciplinary

30. Annex A contains separate unit prices for multiprofessional and single-professional outpatient attendances, which reflect service and cost differences. The multiprofessional price is payable for two types of activity, with the following OPCS codes:

- X62.2: assessment by multiprofessional team not elsewhere classified for multiprofessional consultations[6]
- X62.3: assessment by multidisciplinary team not elsewhere classified for multidisciplinary consultations.[7]

31. 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.

32. 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.

33. The relevant OPCS code should 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.[8]

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

[6] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multi-professional_consultation_(national_tariff_payment_system)_de.asp?shownav=1
[7] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multi-disciplinary_consultation_(national_tariff_payment_system)_de.asp?shownav=1
[8] https://webarchive.nationalarchives.gov.uk/20160921192516/http://systems.digital.nhs.uk/data/nhsdmds/faqs/cds/admitpat/consact

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

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

37. Examples of multidisciplinary attendances are:

- a breast surgeon and an oncologist discuss with the patient options for surgery and treatment of breast cancer
- a respiratory consultant, a rheumatology consultant and a nurse specialist discuss with the patient treatment for a complex multisystemic condition, eg systemic lupus erythematosus
- a patient (and potentially a family member) sees a paediatrician to discuss their disease and a clinical geneticist to discuss familial risk factors.

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

- a consultant and a sonographer, when the sonographer is operating equipment for the consultant to view the results
- a maxillofacial consultant and a dental nurse passing examination instruments to the consultant
- a consultant and a nurse specialist, when the nurse specialist is taking a record of the consultation
- a consultant and a junior doctor, when the junior doctor is present for training
- a consultant ophthalmologist and a nurse, where the nurse administers eye drops or gives the sight exam as part of the consultation.

3.4 Face-to-face and non-face-to-face

39. There are separate HRGs for face-to-face and non-face-to-face attendances, derived from the information recorded in “First attendance”[9].

40. Non-face-to-face attendances are described as “telephone or telemedicine” consultations. Telemedicine is the use of telecommunication and information technology for the purpose of providing remote health assessments and

[9] “First attendance code” or “First attendance” is used to derive the HRG

therapeutic interventions. This could include video or voice messaging services on mobile phones, computers and tablets.[10]

41. The 2020/21 NTPS set non-mandatory prices for non-face-to-face outpatient attendances. These were based on a subset of activity reported in 2016/17 reference costs. For 2021/22, these prices were not published due to:

    - the wider adoption of non-face-to-face services due to COVID-19 meaning the prices may not be representative of current activity
    - the requirement in the aligned payment and incentive rules for providers and commissioners to agree a fixed element to cover an agreed level of activity. This does not make a distinction between delivering activity face-to-face or non-face-to-face, which should be driven by local agreement. Local agreements should also be used for activity outside the scope of aligned payment and incentive agreements to support the most appropriate method of delivering care.

42. Where local agreement on prices for non-face-to-face activity is not possible, the 2020/21 non-mandatory prices should be used.[11] A non-mandatory price of £23 for non-face-to-face outpatient attendances was included in previous tariffs. However, this price was removed in the 2017/19 NTPS and should not be used.

[10] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/t/telemedicine_de.asp?shownav=0

[11] The 2020/21 NTPS documents and prices are available from: www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

4 Chemotherapy and radiotherapy

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

4.1 Chemotherapy delivery

44. HRG subchapter SB covers both the procurement and the delivery of chemotherapy for patients of all ages. The HRGs in this subchapter are unbundled[12] and include activity undertaken in inpatient, day-case and non-admitted care settings.

45. Chemotherapy is split into two parts:

- a core HRG (covering the primary diagnosis or procedure) covered by a unit price but set at £0
- the unbundled HRG for chemotherapy delivery.

46. 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.

47. As all specialised services are in scope of the aligned payment and incentive approach, local pricing and payment arrangements are not expected to apply for these services.

48. Funding for specified high cost drugs (see Annex A, tab 14b) should be included in the aligned payment and incentive fixed element. Some other high cost drugs and Cancer Drugs Fund drugs continue to be paid outside of the tariff. For more details, see Section 5.5 of the 2021/22 NTPS.

[12] To enable HRGs to represent activity and costs more accurately, some significant elements can be “unbundled” from the core HRGs that reflect the primary reason for a patient admission or treatment. These unbundled HRGs better describe the elements of care that comprise the patient pathway and can be commissioned, priced and paid for separately.

49. 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 unit price. The price for SB17Z will continue to be locally negotiated.

50. The cost of the delivery HRGs now includes the cost of supportive drugs listed on the NHS England and Improvement chemotherapy supportive drugs list.[13] This should support a consistent basis for reimbursement and remove the need to report costs at an individual patient level.

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.

[13] 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 Unit price includes cost of delivery	No HRG generated
Day case and outpatient	SB97Z (generated if no other activity occurs)	eg SB14Z Unit prices
Day case and outpatient	If other activity occurs, eg LB35B	eg SB14Z Unit prices
Regular day and regular night admissions	As per day case and outpatient	eg SB14Z Unit prices

51. 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:

    - chemotherapy has taken place
    - the activity has a length of stay less than one day
    - the core HRG which would otherwise be generated is a diagnosis-driven HRG (with no major procedures taking place).

52. 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.

53. As with the national prices in 2020/21, the unit prices do not cover reimbursement for the cost of aseptic units – the prices paid must be locally negotiated.

4.2 Radiotherapy

54. HRG subchapter SC covers both the preparation and delivery of radiotherapy for patients of all ages. The HRGs in this subchapter are for the most part unbundled and include activity undertaken in inpatient, day-case and non-admitted care settings.

55. HRG4+ groups for radiotherapy include:

- radiotherapy planning for pre-treatment (planning) processes
- radiotherapy treatment (delivery per fraction) for treatment delivered, with a separate HRG allocated for each fraction delivered.

56. The radiotherapy planning HRGs are intended to cover all attendances needed to complete the planning process. It is not intended to record individual attendances for parts of this process separately.

57. The planning HRGs do not include the consultation at which the patient consents to radiotherapy, nor any medical review required by any change in status of the patient.

58. The HRGs for radiotherapy treatment cover the following elements of care:

- external beam radiotherapy preparation – this has a unit price
- external beam radiotherapy delivery – this has a unit price
- brachytherapy and molecular radiotherapy administration – this has local currencies and prices.

59. There is a unit price for external beam radiotherapy.

60. 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, should be used by all organisations providing radiotherapy services.

61. 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	Unit 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 Unit prices	eg SC22Z HRG generated Unit prices
Regular day and regular night admissions	As per day case and outpatient	eg SC45Z HRG generated Unit prices	eg SC22Z HRG generated Unit prices

62. 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:

    - external beam radiotherapy has taken place
    - the activity has a length of stay less than one day
    - the core HRG which would otherwise be generated is a diagnosis-driven HRG (with no major procedures taking place).

63. 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 generate an outpatient HRG.

64. Delivery codes will be assigned to each attendance for treatment (only one fraction [HRG] per attendance will attract a price). The only exception to this 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, generates two delivery attendances.

65. 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[14] will attract a price.

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

5 Nuclear medicine

66. Two empty core HRGs for nuclear medicine were introduced in the 2016/17 reference cost currency design. They are RD97Z (diagnostic imaging) and RN97Z (nuclear medicine). Empty core HRGs allow a price to be paid for each scan. In the 2021/22 NTPS these two HRGs have a unit price set at zero for outpatient procedures. This is the same as for other current empty core HRGs.

6 Direct access

67. Annex A, tabs 4 and 5, includes unit prices for activity accessed directly from primary care. One example is where a GP sends a patient for a scan and results are sent to the GP for follow-up rather than such a service being requested as part of an outpatient referral.

68. The outpatient Commissioning Data Set version 6.2 has a field that can be used to identify services that have been accessed directly.[15]

69. Where direct access activity is processed through the grouper, both a core HRG and an unbundled HRG will be created. When the activity is direct access, the core HRG should not attract any payment but the direct access service should attract a payment.

70. In the case of direct access diagnostic imaging services for which there are prices, the costs of reporting are included in prices. Annex A, tab 4, also shows these reporting costs separately so that they can be used if a provider provides a report but does not carry out the scan.

71. There is also an additional non-mandatory guide price for direct access plain film X-rays. See the *Non-mandatory guide prices* workbook.

[15] SUS R16 release (April 2016) has a requirement to add new functionality to implement the CDS6.2 new data item 'Direct access indicator'.

7 Post-discharge rehabilitation

72. Post-discharge currencies remain available to cover the entire pathway of treatment following discharge. They are designed to help reduce avoidable emergency readmissions and provide a service that clinical experts agree will facilitate better post-discharge rehabilitation and reablement for patients.[16]

73. The post-discharge 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.

74. There are four post-discharge unit prices for use where a single trust provides both acute and community services. Other providers may also choose to use these prices. The post-discharge prices cover four areas of care:

- cardiac rehabilitation
- pulmonary rehabilitation
- hip replacement rehabilitation
- knee replacement rehabilitation.

75. There are associated commissioning packs for cardiac rehabilitation[17] and pulmonary rehabilitation.[18]

7.1 Cardiac rehabilitation

76. 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

[16] More information on commissioning rehabilitation services can be found at: www.england.nhs.uk/ahp/improving-rehabilitation

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

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

funding responsibility of the patient's commissioner and is not covered by this price.

77. The currency is based on the care pathway outlined in the commissioning pack on cardiac rehabilitation. If the unit prices are used, commissioners should pay the unit price even where the provider offers a different care pathway. The provider would bear 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.

78. Based on clinical guidance, the post-discharge price applies only 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:

- acute myocardial infarction
- percutaneous coronary intervention or heart failure
- coronary artery bypass grafting.

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

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

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

7.2 Pulmonary rehabilitation

81. 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).[19] If the unit prices are used, commissioners should pay the unit price even where the provider offers a different care pathway. The provider would bear 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.

82. The post-discharge price applies to patients discharged having had an acute episode of care for COPD. The price should 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 details of the evidence base for those discharged from a period of care for COPD who will benefit from pulmonary rehabilitation.

7.3 Hip replacement rehabilitation

83. 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.

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

- seven nurse/physiotherapist appointments
- one occupational therapy appointment
- two consultant-led clinic visits.

85. The unit price applied therefore represents the funding for this rehabilitation pathway and will act as a maximum level of post-discharge rehabilitation payment. If this price is used, 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 would fund the pathway for

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

the first three months after discharge and does not cover long-term follow-up treatment.

86. The unit price should 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.

7.4 Knee replacement rehabilitation

87. 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.

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

- 10 nurse/physiotherapist appointments
- one occupational therapy appointment
- consultant-led clinic visits.

89. The unit 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 would fund the pathway for the first three months after discharge and does not cover long-term follow-up treatment.

90. The unit price should 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.

8 Cystic fibrosis pathway payment

91. 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.

92. The CF pathway currency was designed to support specialist CF multidisciplinary teams to provide care in a seamless, patient-centred manner, removing any incentives to hospitalise patients whose care can be well managed in the community and in their homes. Furthermore, it allows early intervention (following international guidelines) to prevent disease progression – for example, through the use of antipseudomonal inhaled/nebulised antibiotics and mucolytic therapy.

93. 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).

94. Patients are allocated to a band by the Cystic Fibrosis Trust using data from its national database, the UK CF Registry.[20]

95. The pathway payment unit prices are available for use by commissioners and providers and cover all treatment **directly related to cystic fibrosis** for a patient during the financial year. This includes:

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

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

- intravenous antibiotics provided during inpatient spells
- annual review investigations.

96. 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 should be recorded against TFC 264 and TFC 343 and form part of the CF pathway.

97. 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 would need to agree on payment from the prices paid to the specialist CF centre.

98. If the pathway payment approach is used, there some specified services that require further local negotiation on price:

    - high cost CF-specific inhaled/nebulised drugs: colistimethate sodium, tobramycin, dornase alfa, aztreonam lysine, ivacaftor and mannitol.
    - insertion of gastrostomy devices (percutaneous endoscopic gastrostomy – PEG) and insertion of TIVADs are not included in the annual banded prices. These surgical procedures should be reimbursed via the relevant HRG price.
    - 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 should be reimbursed via the relevant HRG price. Once discharged after their initial surgical procedure, subsequent cystic fibrosis treatment should be covered by the cystic fibrosis pathway payment. Annual banding should not include the period they spent as an admitted patient receiving their initial surgical management.

99. 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.

9 Looked-after children health assessments

100. Looked-after children[21] 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.

101. One-third of all looked-after children are placed with carers or in settings outside the originating local authority. These are referred to as ‘out-of-area’ placements.

102. When children are placed in care by local authorities, their responsible health commissioner has a statutory responsibility to commission an initial health assessment and conduct six-monthly or yearly reviews. When the child is placed out-of-area, the originating commissioner retains this responsibility. However, the health assessment should be done by a provider in the child’s local area as 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.

103. Usually, there are clear arrangements between commissioners and local providers for health assessments of looked-after children placed ‘in area’. However, arrangements for children placed out-of-area are variable, resulting in concerns about the quality and scope of assessments.

104. To address this variability in the arrangements for children placed out-of-area and to enable more timely assessments, a national currency was devised, along with and a checklist for implementing it. The checklist should be completed by the health assessor and sent to the responsible commissioner or designated professional. It would be reviewed by the responsible commissioner or designated professional to support payment against the agreed quality. This checklist is set out in Table 5.

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

105. Prices have been set for children placed out of area. These were national prices in previous tariffs but, for 2021/22, they are unit prices (see Annex A).[22] Additional non-mandatory guide prices have been set for health assessments undertaken for children placed in area (available from the *Non-mandatory guide prices* workbook).

106. 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,*[23] published by the Royal College of Nursing, Royal College of General Practitioners and the Royal College of Paediatrics and Child Health.

22 Use of unit prices is not mandatory. Unit prices are available to support local pricing where the aligned payment and incentive approach does not apply (for example, for contracts between providers and commissioners in different ICSs, with a value of less than £10 million).

23 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			
Evidence that the carer's concerns/comments have been sought and recorded			

Child's name:			
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:			

107. Please also see the following guidance:

- Promoting the health and wellbeing of looked after children: revised statutory guidance[24]
- Who pays? Determining responsibility for payment to providers.[25]

[24] www.gov.uk/government/uploads/system/uploads/attachment_data/file/276500/promoting_health_of_looked_after_children.pdf
[25] www.england.nhs.uk/who-pays/

10 Maternity pathway payment

108. The document *Guidance on the aligned payment and incentive approach* includes details on how the approach could be used for maternity services. The information presented here gives details of the maternity pathway payment (MPP), which has been used to pay for maternity services in previous tariffs.

109. In the 2021/22 NTPS, there are two types of unit prices published for maternity services: HRG-level prices and MPP prices. We recommend that any activity-based payments for maternity services are based on HRG-level prices, rather than the MPP prices, as this would:

- reduce the chances of double payment
- reduce the provider-to-provider transactional burden for maternity services
- ensure activity across maternity services is appropriately resourced.

110. However, we have continued to publish MPP prices and provide details of the pathway here.

111. Please note: in the 2019/20 and 2020/21 NTPS, maternity prices were non-mandatory. This was because the maternity pathway payment covered some public health services which, under the Health and Social Care Act 2012,[26] should not be subject to national prices. However, this change was introduced solely to address the mix of services issue.

112. In the 2021/22 NTPS, maternity services have unit prices. Unit prices are calculated using the costs associated with the delivery of the maternity pathways and are subject to the same adjustments for the cost base, cost uplift and efficiency factor as national prices.

113. This section provides guidance on the MPP. Both HRG and MPP prices for maternity services are published in Annex A, along with supporting information on factors, definitions and technical information.

[26] See, in particular, section 116(11) of the 2012 Act.

10.1 Agreeing prices for maternity pathways

Maternity pathway payments

114. Pathway payments are a single payment for a bundle of services that may be provided by several providers for an entire episode or whole pathway of care for a patient. They are designed to encourage better organisation and co-ordination of care across a pathway and among different healthcare providers.

115. The maternity pathway payment system splits maternity care into three phases: antenatal, delivery/birth and postnatal. For each stage, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each phase to cover the cost of care.[27] The level of payment for the antenatal and postnatal phases depends on clinical factors that affect the intensity of care a woman and her well baby are expected to need. The birth episode payment is based on what happens during the birth.

116. Women may receive some of their care from a different provider for clinical reasons or because this is their choice. This is paid for by the lead provider, as it receives the entire pathway payment from the commissioner.

117. Table 6 sets out what is included and excluded from the three stages of the maternity payment system.

Table 6: The maternity pathway payment system

Area	Included	Excluded
Admitted patient care	All activity against NZ*[28] HRGs (regardless of TFC)	All activity against non-NZ* HRGs (regardless of TFC)

27 Antenatal care for uncomplicated pregnancies www.nice.org.uk/guidance/cg62/chapter/guidance
28 NZ* denotes any HRG beginning with the code NZ.

Area	Included	Excluded
Outpatient care	All activity against NZ* HRGs (regardless of TFC) apart from the identified exclusions All attendance activity against TFC 501 (obstetrics) and 560 (midwife episode) - includes **non-specialist** fetal medicine - 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 (obstetrics) or 560 (midwife episode) Emergency gynaecology and early pregnancy activity will normally code to TFC 502 or non-NZ* HRGs and will therefore be excluded **Specialist** fetal medicine
Antenatal education	Antenatal education activity	
Critical care		All maternal and neonatal critical care activity
Community/ primary care	All maternity community-based antenatal/postnatal care	All primary care activity applicable to payment under the GP contract. A woman may choose to have some of her maternity pathway delivered by her GP or for the practice to be the lead pathway provider, but any care delivered by the GP will be paid for under the GP contract
Scans, screening and tests	All maternity ultrasound scans, and all relevant maternal and newborn screening that is part of National Screening Programmes	The analysis elements of the screening process undertaken by specialist diagnostic laboratories under a separate commissioner contract Specialist fetal medicine

Area	Included	Excluded
Immunisation	All specified immunisations of the newborn that should occur before handover to primary care	
Birth	The birth, irrespective of type and setting, with the specified exception	Births for women referred to a specialist centre identified as having an abnormally invasive placenta
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)
Ambulance transfers		Any maternity care provided by an ambulance service
Accident and emergency		All unscheduled A&E activity

Area	Included	Excluded
Clinical Negligence Scheme for Trusts (CNST)	CNST costs related to maternity	
High cost drugs and devices		All specified high cost drugs and devices not covered by national prices

10.2 Structure of the maternity pathway

Introduction

118. This section sets out guidance and business rules for each of the three pathways.

The antenatal pathway

119. The antenatal pathway[29] starts when the pregnant woman has her first antenatal appointment with her maternity provider, at around 10 weeks' gestation. It ends when the birth spell begins or at the termination or miscarriage of the pregnancy.

120. The level of the payment to the provider 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. The level assigned is based on a range of clinical and social characteristics and history from previous pregnancies (factors).

121. The characteristics (factors) that determine casemix level and payment, and details of the technical information relating to the factors, are available in Annex A.

122. A woman may have multiple factors during the antenatal phase. The following allocation rules apply:

[29] 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.

- If a woman has one or more of the ‘intensive resource’ characteristics, she is allocated to the intensive pathway, irrespective of any other factors.
- 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. Irrespective of how many intermediate factors the woman has, this is the correct resource level allocated for her care.
- If a woman does not have any of the listed characteristics, she is allocated to the standard resource pathway.

123. Some women develop complications during their 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 based on the reported average cost for women on the pathway. This takes into account changes in complexity for a proportion of women.

Pregnancies that end early

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

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

The birth episode pathway

126. The birth episode begins at the point of admission for birth or induction of labour 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.

127. There are seven delivery pathway prices, including a setting-specific price for home births. The remaining six prices are mapped from HRGs, as set out in Annex A.

128. 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 intrapartum episode up to transfer of responsibility to community 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.

129. Home births are subject to a setting-specific price and continue to be collected in the admitted patient care other delivery event commissioning dataset (CDS). This price is based on the 'without complications' delivery price but adjusted for efficiency, the cost uplift factor, centralised procurement and CQUIN adjustments.

130. An additional daily payment will apply for patients who stay in hospital longer than the trim point associated with the applied delivery phase level.

The postnatal pathway

131. The postnatal pathway begins after the woman and her baby or babies have been transferred to community postnatal care and ends after they have transferred to primary care and/or health visiting services.

132. 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 woman is discharged after the delivery episode and is based on her specific health and social care characteristics collected at the antenatal booking appointment, which can be supplemented with information gathered over her pregnancy. For details of the postnatal risk factors, see Annex A.

133. The 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. If the woman and her baby are separated, e.g. for a social services removal, the lead provider is the one that accepted the woman and should agree a reasonable split of the payment with any other providers.

134. All postnatal care, as defined in NICE clinical guideline 37 *Postnatal care up to 8 weeks after birth*[30], 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 a health visitor. There is no defined time period for provision of community postnatal care by the maternity team.

135. There are some specific exceptions for postnatal complications, which should be paid for based on the relevant HRGs. NICE guidance identifies the following complications as requiring immediate urgent acute care:

- postpartum haemorrhage
- genital tract sepsis
- venous thromboembolism
- breast mastitis, abscess
- postnatal wound infection requiring surgery
- pulmonary embolism.

136. Payment will be claimed in the usual way from local commissioners. If these complications are identified before discharge from hospital after the birth, they are included in the birth payment.

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

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

Arrangements between providers

139. A woman may receive some of her care from a provider other than her lead provider for clinical reasons or because this is her choice. In this case, the lead provider that received payment from a commissioner will need to pay the other organisation. This also applies if a pregnant woman needs care from another

30 www.nice.org.uk/guidance/cg37

NHS provider while she is on holiday or unable to access her lead pathway provider.

140. Further guidance[31] has been published on the nature of the arrangements between the providers and on information flows.

141. Prices must be agreed between the two providers. For some activity, non-mandatory guide prices are provided in the *Non-mandatory guide prices* workbook. These are a guide to the amounts to be invoiced and paid between providers. Providers should be proportionate and fair in invoicing the lead provider. Providers must not invoice local commissioners for NZ* HRGs or TFC 501/560 activity or elements of maternity care costs. In the case of doubt, help can be sought from Commissioning Support Units or Data Services for Commissioners Regional Offices to establish which organisation is the lead provider.

142. The amount invoiced should reflect the primary reason the woman accessed an alternative maternity provider. For example, if this was for an antenatal obstetric opinion, the antenatal clinic attendance should be invoiced, irrespective of whether the woman was subsequently referred on for additional investigations.

143. In certain cases, a woman may change her lead antenatal 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 7). This table was developed through analysis of the pathway costing data provided by NHS trusts and foundation trusts and input from our clinical advisors.

Table 7: Proportion of pathway price to refund or transfer on change of pathway provider

Gestational age	% of the antenatal MPP by gestational age	% of the total antenatal MPP retained by lead provider
5–15+6 weeks	26%	26%
16+0–20+6 weeks	19%	45%
21+0–24+6 weeks	7%	52%

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

Gestational age	% of the antenatal MPP by gestational age	% of the total antenatal MPP retained by lead provider
25+0–30+6 weeks	14%	66%
31+0–35+6 weeks	14%	80%
36+0–40+6 weeks	14%	94%
≥41 weeks	6%	100%

144. A new 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.

145. When a woman changes both commissioner and provider (e.g. if she moves to a new house), any refunds to the original commissioner (by the original lead provider) are based on the original categorisation at the antenatal assessment appointment. For example, 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 8 below to aid understanding of this issue.

Table 8: Examples of transfer scenarios[32]

Action/activity	Consequence
Example 1	
Woman categorised as standard care based on antenatal assessment appointment information	Payment of, for example, £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 (one of the intensive factors)
Woman moves lead provider in week 29, no change in commissioner	Change in provider

[32] Please note: this example does not use actual prices.

Action/activity	Consequence
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, for example, £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 provider B

Information flows for the antenatal and postnatal pathways

146. The Maternity Services Data Set (MSDS) has collected data since April 2015. More information on data collection and reporting can be found on the NHS Digital website.[33]

[33] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set

11 Critical care – adult, paediatric and neonatal

226. Critical care is a high cost, low volume service that requires intense management and monitoring of the patient using advanced nursing, therapy and medical skills. It is difficult to predict which patients will require critical care and most of its activity is unplanned.

227. The healthcare resource group (HRG) currencies for adult, paediatric and neonatal critical care services are derived from a subset of the critical care minimum datasets.

11.1 Adult critical care

228. A critically ill adult 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.

229. Adult critical care currencies provide structure for commissioners and providers when agreeing expected activity levels and associated payment.

230. The HRGs for adult critical care (subchapter XC) have been designed using the level of support required by the patient, indicated by the total number of organs supported (0–6) during the critical care period.

Table 9: 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

11.2 Paediatric critical care

231. Paediatric critical care (PCC) is the provision of close observation, monitoring and therapies to children who are, or have a significant potential to be, physiologically unstable which is beyond the intensity of support that can be delivered in a general paediatric ward.

Levels of paediatric critical care delivery

Level 1; Basic paediatric critical care

232. All hospitals delivering inpatient care to children should be able to deliver level 1 PCC care, within either a paediatric ward or a high dependency unit.

Level 2; Intermediate paediatric critical care

233. A more limited number of hospitals should be designated as Level 2 PCC units and able to deliver Intermediate PCC (as well as Basic PCC) to children within a defined critical care area.

234. All providers of Level 3 care (paediatric intensive care units – PICUs) should be designated to provide Level 2 care. This may be delivered within a combined Level 3/Level 2 critical care unit or within a Level 2 critical care unit that is geographically distinct from the Level 3 unit.

235. A limited number of additional (non-Level 3) providers across each paediatric critical care Operational Delivery Network (ODN) may be designated as Level 2 critical care units and be expected to deliver Level 2 (and Level 1) care.

Level 3; Advanced paediatric critical care (also known as paediatric intensive care).

236. Level 3 PCC units, also known as PICUs, are usually located in tertiary centres or specialist hospitals and can provide all 3 levels of PCC.

Currencies, data sets and cost weightings

237. The HRGs for paediatric critical care services (subchapter XB, see Table 10 below) are determined daily by the level of critical care resource usage (eg, medical and nursing staff costs, equipment and drug costs associated with the care required for a patient).

238. HRGs are derived through the daily collection of the Paediatric Critical Care Minimum Dataset (PCCMDS) version 2.0, consisting of 36 diagnostic and

intervention variables (‘critical care activity codes’). An algorithm (or ‘grouper’) takes the daily data and, according to which PCCMDS activity codes are recorded, allocates a daily HRG from XB01Z to XB07Z. The hierarchy is ordered for complexity, with XB01Z representing a higher level of care than XB07Z.

239. XB01Z to XB05Z describe Level 3 PCC, whilst XB06Z describes Level 2 PCC and XB07Z describes Level 1 PCC.

Table 10: HRG currencies for paediatric critical care

HRG code	Description
XB01Z	Paediatric Critical Care, Advanced Critical Care 5
XB02Z	Paediatric Critical Care, Advanced Critical Care 4
XB03Z	Paediatric Critical Care, Advanced Critical Care 3
XB04Z	Paediatric Critical Care, Advanced Critical Care 2
XB05Z	Paediatric Critical Care, Advanced Critical Care 1
XB06Z	Paediatric Critical Care, Intermediate Critical Care
XB07Z	Paediatric Critical Care, Basic Critical Care
XB08Z	Paediatric Critical Care, Transportation
XB09Z	Paediatric Critical Care, Enhanced Care

240. XB08Z relates to paediatric critical care transport

241. XB09Z (enhanced care) represents the resources involved in providing critical care within a PICU to children who do not trigger any of the PCCMDS activity codes required for grouping to XB01Z to XB07Z. This HRG was added to the original seven HRG codes in order to be able to capture levels of activity occurring within a PICU not mapping to any of the HRGs. It can also be described as Level 0 care.

242. Data from the PCCMDS version 2.0 (2016 release) has been used to inform the reporting of reference costs against the PCC HRGs from 2016/17 onwards (national cost collection from 2018/19 onwards). This means we have a greater understanding of service provision.

243. Data should be “grouped” using the correct grouping logic that processes the activity to the correct HRG. For example, the HRG4+ 2021/22 Local Payment Grouper will be used for the 2021/22 NTPS, whereas the HRG4+2018/19 Reference Cost Grouper was used for the 2018/19 national cost collection.

244. Cost and activity data were submitted to the 2018/19 national cost collection by the following unit types, which are recorded in the Critical Care Unit Function field in the PCCMDS:[34]

- 04: Paediatric intensive care unit (Paediatric critical care patients predominate).
- 16: Ward for children and young people.
- 17: High Dependency Unit for children and young people.

245. To understand how care should be delivered and to disincentivise care being delivered in the wrong place we recommend that:

- HRG XB01Z (Extracorporeal membrane oxygenation, ECMO, and ventricular assist devices, VAD) can only occur in a paediatric cardiac surgical centre, of which there are only 10 across England (see Table 11).
- HRG XB02Z-XB05Z can only occur within one of the 20 designated PICU (Level 3) providers across England (see Table 12).
- HRG XB06Z, XB07Z and XB09Z can occur in a PICU, or a High Dependency Unit (HDU), or within a ward for children and young people.

246. ECMO support is indicated for acute, severe but reversible respiratory failure when the risk of dying from the primary disease despite optimal conventional treatment is high (so called ‘respiratory ECMO’), or in the setting of severe cardiovascular failure which is felt to be at least partially reversible and likely to result in death unless ECMO is initiated (so called ‘cardiac ECMO’).

Table 11: Paediatric cardiac surgical centres in England

Organisation Code	Organisation Name
RBS	Alder Hey Children's NHS Foundation Trust
RQ3	Birmingham Children's Hospital NHS Foundation Trust
RP4	Great Ormond Street Hospital for Children NHS Trust
RJ1	Guy's and St Thomas' NHS Foundation Trust

[34] https://datadictionary.nhs.uk/attributes/critical_care_unit_function.html

Organisation Code	Organisation Name
RR8	Leeds Teaching Hospitals NHS Trust
RT3	Royal Brompton and Harefield NHS Foundation Trust
RHM	Southampton University Hospitals NHS Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
RA7	University Hospitals Bristol NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust

Table 12: Designated PICU (Level 3) providers across England

Organisation Code	Organisation Name
RBS	Alder Hey Children's NHS Foundation Trust
R1H	Barts Health NHS Trust
RQ3	Birmingham Children's Hospital NHS Foundation Trust
RGT	Cambridge University Hospitals NHS Foundation Trust
R0A	Manchester University NHS Foundation Trust
RP4	Great Ormond Street Hospital for Children NHS Trust
RJ1	Guy's and St Thomas' NHS Foundation Trust
RYJ	Imperial College Healthcare NHS Trust
RJZ	King's College Hospital NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RX1	Nottingham University Hospitals NHS Trust
RTH	Oxford Radcliffe Hospitals NHS Trust
RT3	Royal Brompton and Harefield NHS Foundation Trust
RCU	Sheffield Children's NHS Foundation Trust
RHM	Southampton University Hospitals NHS Trust
RJ7	St George's Healthcare NHS Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
RJE	University Hospital of North Staffordshire NHS Trust
RA7	University Hospitals Bristol NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust

247. To reflect the staffing and resource requirements of the elements of care we would usually expect that the cost of:

- XB01Z would be approximately three times the cost of XB05Z
- XB02Z would be approximately twice the cost of XB05Z

- XB03Z would be approximately one and a half times the cost of XB05Z
- XB04Z would be approximately one and a quarter times the cost of XB05Z
- XB06Z/XB07Z would be lower than the cost of XB05Z
- XB09Z would usually be expected to be approximately the same as the cost of providing a standard paediatric bed day.

248. These weightings are supported by an observational study that was undertaken across 10 PICUs as part of original HRG development and are expressed relative to XB05Z.

249. These weightings will be subject to refinement over time.

Table 13: Relative weights for Paediatric Critical Care HRGs

HRG	Description	Relative Weight
XB01Z	Paediatric Critical Care, Advanced Critical Care 5	3.0
XB02Z	Paediatric Critical Care, Advanced Critical Care 4	2.0
XB03Z	Paediatric Critical Care, Advanced Critical Care 3	1.50
XB04Z	Paediatric Critical Care, Advanced Critical Care 2	1.25
XB05Z	Paediatric Critical Care, Advanced Critical Care 1	1.0
XB06Z	Paediatric Critical Care, Intermediate Critical Care	0.75
XB07Z	Paediatric Critical Care, Basic Critical Care	0.60
XB09Z	Paediatric Critical Care, Enhanced Care	0.40

Structure and setting of non-mandatory guide prices

250. These services do not have unit prices calculated using the method for national and unit prices in Section 6 of the 21/22 NTPS. However, we have determined and published non-mandatory guide prices for paediatric critical care to support the development of local prices. See the *Non-mandatory guide prices* workbook for further details.

251. In setting these guide prices we have used data from the 2018/19 national cost collection, applied the general tariff calculation method and, after determining national average unit costs, have then applied the relative weights from Table 13 to reweight the costs.

252. These prices should be subject to further refinement and review and commissioners and providers should work together to review their application.

253. XB08Z relates to Paediatric critical care transport. Due to the wide variation in cost there is no expected cost weighting against other HRGs and we have not set a non-mandatory guide price for this HRG.

11.3 Neonatal critical care

254. Neonatal critical care includes care for all patients requiring significant additional support in the neonatal period.

Currencies, data sets and cost weightings

255. The HRGs for neonatal critical care services (subchapter XA) are determined by the level of critical care support, interventions and procedures. These are closely aligned to British Association of Perinatal Medicine (BAPM) Categories of Care 2011.[35]

Table 14: 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

256. The Neonatal Critical Care Minimum Data Set 2016 (NCCMDS) has been updated to reflect the BAPM Categories of Care 2011, with further clarifications regarding special care with and without carer present, and what should be considered normal maternity care (which would not be recorded in the data set and thus not generate a critical care HRG).

257. The NCCMDS was approved as a standard for use by the Standardisation Committee for Care Information (SCCI). Full details of the NCCMDS database

35 www.bapm.org/resources/34-categories-of-care-2011

are published on the NHS Digital website: http://content.digital.nhs.uk/isce/publication/scci0075.

258. Data from the NCCMDS version 2.0 (2016 release) has been used to inform the reporting of reference costs against the unbundled HRGs XA01Z to XA05Z from 2016/17 onwards.

259. This means we have a greater understanding of service provision. Cost and activity data has been submitted by the following facility types, which are recorded in the Critical Care Unit Function field in the NCCMDS:[36]

- 13: Neonatal intensive care unit (includes neonatal intensive care units (NICU), local neonatal units (LNU) and special care units (SCU)).
- 14: Facility for babies on a transitional care ward.
- 15: Facility for babies on a maternity ward.

260. To understand how care should be delivered, and to disincentivise care being delivered in the wrong place, we recommend that in the main:

- HRGs XA01Z, XA02Z and XA03Z should only ever be generated in a neonatal unit
- HRGs XA04Z and XA05Z can be generated in a neonatal unit, a transitional care unit or a maternity ward.

261. To reflect staffing and the requirements of the element of care, we would usually expect that the cost of:

- XA01Z would be at least four times the cost of XA03Z
- XA02Z would be at least twice the cost of XA03Z
- XA03Z and XA04Z would be similar
- XA05Z would be lower than the cost of XA03Z/XA04Z but would not usually be expected to be less than the cost of providing a standard paediatric/ neonatal bed day.

36 www.datadictionary.nhs.uk/data_dictionary/attributes/c/cou/critical_care_unit_function_de.asp?shownav=1

262. These HRG weightings are based on the BAPM Service Standards for Hospitals providing Neonatal Care 2010.[37] They are provided as a guide (see Table 15) and will be subject to refinement over time.

Table 15: Guide weightings for neonatal critical care HRGs

HRG	Description	Relative Weight
XA01Z	Neonatal Critical Care, Intensive Care	4.0
XA02Z	Neonatal Critical Care, High Dependency	2.0
XA03Z	Neonatal Critical Care, Special Care, without External Carer	1
XA04Z	Neonatal Critical Care, Special Care, with External Carer	0.8
XA05Z	Neonatal Critical Care, Normal Care	0.6

Types of neonatal unit and levels of care

263. There are three types of neonatal unit, which deliver three levels of care.[38] These units and their levels of care are listed in Table 16.

Table 16: Types of Neonatal unit and types (levels) of care

Level of Care	Common acronym	Type of Neonatal Critical Care Unit
1	SCU	Special Care Unit
2	LNU	Local Neonatal Unit (this delivers high dependency care)
3	NICU	Neonatal Intensive Care Unit

264. Some NHS trusts host more than one neonatal unit. Of the 44 Neonatal Intensive Care Units (Level 3 care) across England, 18 also support a co-

37 www.bapm.org/resources/32-service-standards-for-hospitals-providing-neonatal-care-3rd-edition-2010

38 The Neonatal Level Of Care is recorded in the main Admitted Patient Care data set in SUS (ie together with the core episode activity, rather than on the NCCMDS). The Neonatal Level Of Care code for Neonatal Intensive Care Unit is 3. However, due to an earlier naming definition/convention, the NHS data dictionary retains 'Level 1 Intensive Care' in the description. www.datadictionary.nhs.uk/data_dictionary/attributes/n/ne/neonatal_level_of_care_de.asp?shownav=1

located neonatal surgical service.[39] Sections 3.2.2 to 3.2.7 (pages 6-9) of the Service Specification for Neonatal Critical Care (Intensive Care, HDU and Special Care) describe in some detail the services provided by each type of neonatal unit.[40]

265. In addition to the above expectations of relative weighting of cost according to HRG (see paragraph 261 above and Table 15), we would expect the cost of service provision to be reflective of the different staffing and resource requirements of the type of neonatal unit in which the care is delivered (and in the case of Neonatal Intensive Care Units, whether they also support a co-located neonatal surgical service).

Structure and setting of non-mandatory guide prices

266. These services do not have unit prices calculated using the method for national and unit prices in Section 6 of the 21/22 NTPS. However, we have determined and published non-mandatory guide prices for neonatal critical care services to support the development of local prices. See the *Non-mandatory guide prices* workbook for further details.

267. In setting the non-mandatory guide prices, we have attempted, as far as possible within the bounds of the method for setting prices, to:

- map reference costs for the unbundled HRGs XA01Z to XA05Z to the type of neonatal unit (and split NICU according to whether it supports a co-located neonatal surgical service)
- meet the expectations detailed in paragraph 261 above and Table 15.

268. The non-mandatory guide prices will be subject to further testing and review. Commissioners and providers should work together to review their application.

269. XA06Z relates to neonatal critical care transport and its non-mandatory price has not been subject to weighting against other HRGs or split according to type of neonatal unit. Its price is not considered to differ according to the type of neonatal unit, however due to the wide variation in cost we have not set a non-mandatory price for this HRG.

39 Implementing the Recommendations of the Neonatal Critical Care Transformation Review, page 6. Document first published 13 December 2019. Available from:

40 www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e08-serv-spec-neonatal-critical.pdf

270. As the Neonatal Level Of Care (corresponding to the Type of Neonatal Critical Care Unit in Table 16), is recorded together with the Admitted Patient Care core episode activity in SUS, rather than on the NCCMDS, the grouped Neonatal Critical Care activity needs to be linked back to the core episode record for correct assignment of non-mandatory guide prices of HRGs XA01Z to XA05Z.

271. Since the Neonatal Level Of Care does not specify whether a Neonatal Intensive Care Unit supports a co-located neonatal surgical service, work is ongoing to provide further information on the eligible lists of providers. Please contact pricing@improvement.nhs.uk if you have any questions about this.

12 Dialysis for acute kidney injury

272. 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.

273. National prices and unit prices have not been set for these services, but non-mandatory guide prices are available for haemodialysis for acute kidney injury, 19 years and over (LE01A) and peritoneal dialysis for acute kidney injury, 19 years and over (LE02A). There are national currencies for LE01B and LE02B – see Annex A for details.

13 HIV adult outpatient services pathway currencies

274. 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.

275. 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 account of ongoing changes in service delivery.

13.1 The currency model

276. The HIV outpatient currencies are a clinically designed pathway for each of three groupings of adults (aged 18 years and older) with HIV – see Table 17. The currencies support an annual year-of-care payment approach.

277. The HIV adult outpatient currencies do not include the provision of any antiretroviral (ARV) drugs. The currency model applies when patients move from one provider to another.

Table 17: HIV adult outpatient currencies

HIV adult outpatient currencies
Category 1: New patients
Category 1 patients are newly diagnosed in England or have newly started on ARV drugs. 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. A newly diagnosed patient will be a Category 1 patient for one year, after which they will automatically become a Category 2 patient, unless they start ARV drugs for the first time during the year. A patient starting ARV drugs for the first time will be a Category 1 patient for one year then they will automatically become a Category 2 patient.

HIV adult outpatient currencies
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. If a patient is Category 1, but has one of the Category 3 listed complexities they become a Category 3 patient for a year.
Category 2: Stable patients
Category 2 covers patients who do not have one of the listed Category 3 complexities and are either not on ARV drugs or started ARV drugs more than one 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.

278. 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.

279. National guidance for the provision of treatment and an appropriate service specification can be found at www.bhiva.org and www.bashh.org.

280. 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 and Social Care.[41]

41 www.gov.uk/government/publications/hiv-outpatient-pathway-updated-guidance-available

14 Renal transplant

281. 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.

282. For suitable patients it is preferable to perform a pre-emptive transplant (within six months of needing dialysis) where possible.

283. 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.

284. These services do not have unit prices calculated using the method for national and unit prices in Section 6 of the 21/22 NTPS. However, we have determined and published non-mandatory guide prices for renal transplant services to support the development of local prices. See the *Non-mandatory guide prices* workbook for details.

14.1 What is the renal transplant currency?

285. The currency uses existing healthcare resource groups (HRGs) and covers all care directly relating to the preparation and provision of renal transplant services, recognising that is delivered in both transplant and specialist renal centres. The currency covers the adult kidney transplantation patient pathway that relates to the preparation and provision of a transplant episode, including living donation, and the required outpatient post-transplant care but excluding unplanned admissions for the management of complications.

286. This currency does not apply to kidney transplants performed as part of simultaneous pancreas and kidney transplants, or other multi-organ transplants incorporating a kidney transplant.

14.2 What does the pathway cover?

287. There are already HRGs relating to this activity: LA01A, LA02A, LA03A, LA10Z, LA11Z, LA12A, LA13A, LA14Z and LB46Z. There are also outpatient procedure codes: M171, M172, M173, M174 and M175. The HRGs are summarised in Table 18 and described in more detail in sections 14.3 and 14.4.

288. The kidney transplant pathway includes the following components, which all map to HRG codes:

- LA12A – Kidney pre-transplantation work-up of recipient
- LA12A – Maintenance on the transplant list
- Kidney transplant episode
  - LA01A: Kidney transplant from cadaver non-heart beating donor 19 years and over
  - LA02A: Kidney transplant from cadaver heart beating donor 19 years and over
  - LA03A: Kidney transplant from live donor 19 years and over
  - LA13A: Examination for post-transplantation of kidney.

289. The live donor pathway covers the following components which all map to HRG codes:

- LA10Z: Live donor screening
- LA11Z: Kidney pre-transplantation work-up of live donor
- LB46Z: Live donation of kidney
- LA14Z: Examination for post-transplantation of kidney of live donor.

290. The kidney transplant episode and the live donation of kidney are inpatient episodes delivered in kidney transplant centres. The other parts of the pathway are outpatient activity delivered in kidney transplant centres and specialist renal units. Before transplantation, patients will be under the care of the renal units and will be on dialysis or being prepared for dialysis.

14.3 What is included in the price?

291. The non-mandatory guide price covers all outpatient and inpatient activity in the adult kidney transplant patient pathway and the live donor pathway. There are several phases associated with the pathway:

Transplant assessment

292. Nephrology work-up of transplant recipients should be captured within the existing multidisciplinary tariff of the low clearance clinic subspecialty code 362. Specialist investigations (anything other than a plain X-ray) and specialist clinical opinion are unbundled from this code.

293. The kidney transplant currency will begin at the point the patient is seen by the transplant surgeon in preparation for transplant listing, which is in keeping with the renal transplant service specification. This will include one multiprofessional clinic visit during which the patient will see the surgeon (45 minutes), the recipient co-ordinator (45 minutes) and have a histocompatibility and immunogenetics (H&I) assessment with listing requirements. This should be captured by outpatient code M172, which maps to HRG code LA12A.

Live donor assessment

294. This activity will include assessment of live donor suitability, multidisciplinary review, work-up of potential living donor and independent assessment. Live donor screening assumes one 60-minute new appointment with the living donor co-ordinator and H&I assessment. Live donor assessment assumes:

    - one 45-minute new appointment with a nephrologist
    - one 45-minute new appointment with a transplant surgeon
    - one 30-minute follow-up appointment with the living donor co-ordinator
    - one two-hour new appointment with independent assessor.

295. Outpatient activity will be captured by procedure codes M171 and M173, which map to HRG codes LA10Z and LA11Z. Reimbursement of expenses for living donor costs is not covered by this guidance; please refer to the NHS England commissioning policy: www.england.nhs.uk/publication/commissioning-policy-reimbursement-of-expenses-for-living-donors/

Maintenance on the transplant list

296. This will include: one annual transplant-focused clinic appointment; three monthly H&I antibody measurements; list maintenance. It will be captured by outpatient procedure code M172, which maps to HRG code LA12A. Patients should receive an annual transplant-focused review based on the requirements of the service specification. This will usually be delivered in the transplant centre but may be delivered in the specialist renal unit.

The transplant episode

297. Activity is captured by one of three HRG codes (LA01A, LA02A and LA03A), depending on whether the donor is non-heart beating (DCD), heart-beating (DBD) or live donor (LD). LA01A and LA02A will always be captured as a non-elective inpatient activity and LA03A as elective inpatient activity.

298. Each will also include the H&I crossmatch test.

Live donor nephrectomy

299. This should be captured by HRG code LB46Z as elective inpatient activity.

Post-transplant follow-up.

300. Post-transplant follow-up will take place within either the transplant centre or the specialist renal centre. It is assumed that follow-up attendances will be around 36 visits in Year 1, and two to four visits per year in subsequent years. Within Year 1, five H&I antibody determinations will be performed.

301. Most patients will be returned to their referring renal unit within the first year at any point from the time of discharge from the inpatient transplant episode to 12 months, although most will go at discharge, three months or six months. Outpatient activity will be captured by outpatient procedure code M174, which maps to HRG code LA13A, and will be reimbursed by episode of care. This will ensure recorded activity is reimbursed at the appropriate specialist centre. The option of having separate HRG codes for Year 1 (episode of care) and Year 2 (year of care) is currently being explored.

Live donor follow-up

302. This can take place within the transplant centre, the specialist renal centre or at a general practice in the long term. Follow-up attendances (four in Year 1, and annual attendance thereafter) are assumed.

303. Outpatient activity will be captured by outpatient code M175, which maps to HRG code LA14Z.

14.4 What is excluded from the price?

304. The following are explicitly not included in the non-mandatory guide price:

- The consultation at which all modalities of renal replacement therapy are considered.
- All immunosuppression drugs, CMV prophylaxis/treatment drugs and hepatitis B prophylaxis drugs that are on the NHS England list of directly commissioned drugs, as these will be funded by pass-through payments.
- Kidney transplants with simultaneous pancreas transplants, or other multi-organ transplants incorporating a kidney transplant.
- Deceased donor organ donation and costs related to the associated organ retrieval.
- Antibody incompatible (ABOi and HLAi) transplantation, but this will be included in future.

305. Patients or donors on the transplant or live donor pathway may require specialist medical input from other specialties as part of the assessment or follow-up process. The pathway is only responsible for transplant care and any costs relating to non-transplant specific care are not included in the price. These episodes of care should be covered by tariffs or prices assigned to the relevant HRG or treatment function code (TFC), eg cardiological assessment of potential transplant recipients.

306. Patients or donors on the transplant or live donor pathway may require specialist investigations from other specialties as part of the assessment or follow-up process. The costs relating to these are unbundled and not included in the price. These episodes of care will be covered by the assigned to the relevant HRG or TFC, eg CT scan or coronary angiogram.

307. Any post-discharge admissions which are transplant-related are usually multifactorial and may relate to rejection, infection, surgical complications or any other form of transplant dysfunction and would not be picked up by one of the transplant pathway HRGs. This also includes ureteric stent and PD catheter removal.

14.5 Drugs

308. Prescription of all immunosuppressive drugs, CMV prophylaxis/treatment drugs and hepatitis B prophylaxis drugs will be initiated and prescribed long term by the kidney transplant centre or specialist renal centre.

309. All commissioned immunosuppression drugs, CMV prophylaxis/treatment drugs and hepatitis B prophylaxis drugs are excluded from the price and will be

funded through a pass-through mechanism. For a list of excluded drugs, see: www.england.nhs.uk/publication/nhs-england-drugs-list/

310. The impact of the introduction of any new high cost drugs approved for use in kidney transplantation will need to be considered through the normal commissioning arrangements.

Table 18: Summary of kidney transplant HRG codes and associated activity

HRG	Code descriptor	Activity included in currency	Activity excluded from currency	Comments
Kidney transplant pathway				
LA12A (OP procedure code M172)	Kidney pre-transplantation work-up of recipient	• Surgical outpatient visit (including consent) • H&I assessment • Transplant listing	• Any radiological or cardiology investigations except CXR and ECG • Any specialist opinion including nephrectomy or preparatory urological procedure	Nephrology work-up of transplant recipients captured within the existing multidisciplinary tariff of the low clearance clinic subspecialty code 362
LA12A (OP procedure code M172)	Maintenance on the transplant list	• Annual transplant-focused outpatient visit and three-monthly antibody assessment • List maintenance	• Any radiological or cardiology investigations except CXR • Any specialist opinion • More frequent antibody testing in high risk cases	
LA01A	Kidney transplant from cadaver non-heart beating (DCD) donor 19 years and over	Inpatient transplant episode	• Any radiological investigation except CXR and ECG • All immunosuppression drugs, CMV prophylaxis/ treatment drugs and hepatitis B prophylaxis drugs that are directly commissioned • Any emergency readmission • Removal of ureteric stent or PD catheter unless done on initial admission	
LA02A	Kidney transplant from cadaver heart beating donor (DBD) 19 years and over	Inpatient transplant episode	• Any radiological investigation except CXR and ECG • All immunosuppression drugs, CMV prophylaxis/ treatment drugs and hepatitis B prophylaxis drugs that are directly commissioned	

HRG	Code descriptor	Activity included in currency	Activity excluded from currency	Comments
			• Any emergency readmission • Removal of ureteric stent or PD catheter unless done on initial admission	
LA03A	Kidney transplant from live donor 19 years and over	Inpatient transplant episode	• Any radiological investigation except CXR and ECG • All immunosuppression drugs, CMV prophylaxis/ treatment drugs and hepatitis B prophylaxis drugs that are directly commissioned • Any emergency readmission • Removal of ureteric stent or PD catheter unless done on initial admission • Antibody or blood group incompatible transplantation	
LA13A (OP procedure code M174)	Examination for post-transplantation of kidney	• Outpatient visit • Routine bloods including post-transplant antibody determination	• All immunosuppression drugs, CMV prophylaxis/ treatment drugs and hepatitis B prophylaxis drugs that are directly commissioned • Any radiological or cardiology investigations except CXR • Any specialist opinion • Any emergency readmission • Removal of ureteric stent or PD catheter unless done on initial admission	Telephone clinics included if OP procedure code M174 used

HRG	Code descriptor	Activity included in currency	Activity excluded from currency	Comments
Live donor pathway				
LA10Z (OP procedure code M171)	Live donor screening	• Outpatient visit • Routine blood and urine tests • H&I assessment		Telephone clinics included if OP procedure code M171 used
LA11Z (OP procedure code M173)	Kidney pre-transplantation work-up of live donor	• Outpatient visit • Routine bloods tests • H&I assessment • Independent assessor	• Any radiological or cardiology investigations except CXR • Any specialist opinion • Reimbursement of live donor expenses	
LB46Z	Live donation of kidney	• Inpatient live donor nephrectomy episode	• Any radiological investigation except CXR • Any emergency readmission	
LA14Z (OP procedure code M175)	Examination for post-transplantation of kidney of live donor	• Outpatient visit • Routine bloods	• Any radiological or cardiology investigations except CXR • Any specialist opinion	Telephone clinics included if OP procedure code M175 used

15 Specialist rehabilitation

311. A currency model based on provider categorisation and patient need has been developed by the UK Rehabilitation Outcome Collaborative (UKROC).[42] It aims to improve capacity, co-ordinate service provision and improve access to specialist rehabilitation services.

312. 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.

313. 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.

15.1 The currency model

314. The currency model was first introduced in the 2013/14 Payment by Results (PbR) 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 prescribed specialised services (PSS) for rehabilitation.[43] The same definitions are used to inform the NHS England service specification for specialised rehabilitation for patients with highly complex needs.

315. The currency model only covers the admitted patient stay for people with Category A or B needs (according to the PSS admitted to designated adult Level 1 and 2 and children's specialist rehabilitation services).

316. 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.

42 www.ukroc.org/
43 https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-pss-tools

317. 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).

318. 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 2 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.

319. Level 2b services must submit their dataset at least quarterly.

320. More detailed guidance on implementation and use of the WBD currency model has been prepared through the Clinical Reference Group for Specialist Rehabilitation.[44]

15.2 Non-mandatory benchmark prices

321. Following work with commissioners and clinicians, through the National Casemix Office Expert Working Groups, the UK Rehabilitation Outcomes Collaborative (UKROC), and the then NHS England Specialised Commissioning clinical reference groups (CRGs) we set non-mandatory prices for the 2019/20 NTPS, based on UKROC costing and activity data. These prices are again made available for use in 2021/22 (see the *Non-mandatory guide prices* workbook for details).

322. Costs for specialist rehabilitation are not reported through the national cost collection, but through a submission to the UKROC. This dataset is now funded by NHS England and NHS Improvement Specialised Commissioning. Submission to the dataset is a commissioning requirement.

[44] www.csi.kcl.ac.uk/commissioning-tools.html

16 Ambulance services

323. This section details currencies for ambulance services and what to include and exclude if applying these currencies. Any services not specified in these lists are not subject to these currencies.

324. **Urgent and emergency care calls answered:** the unit for payment is per call.

- The number of emergency and urgent calls presented to switchboard and answered.
- 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). For 111 calls that are manually transferred (not via Interoperability Toolkit – ITK), do not double count as incoming calls and as 111 activity.
- 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.
- Exclude calls abandoned before answered, patient transport services requests, calls under any private, non-NHS contract or internal calls from crews.

325. **Hear and treat/refer:** the unit of payment is per patient.

- 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.
- A precondition of this currency is that, as a result of the call, an ambulance trust healthcare professional does not arrive on scene.
- Include patients whose call is resolved – without despatching a vehicle – 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.
- All exclusions for hear and treat/refer are listed in the Ambulance Quality Indicators and can be found on the NHS England Ambulance Quality Indicators web page.

326. **See and treat/refer:** the unit of payment is per incident.

- The number of incidents resolved with the patient(s) being treated and discharged from ambulance responsibility on scene without conveyance of the patient(s).
- Include incidents where ambulance service staff arrive on the scene and refer (but do not convey) the patient(s) to any alternative care pathway or provider.
- Include incidents where, on arrival at scene, ambulance service staff are unable to locate a patient or incident.
- Include incidents despatched by third parties (such as 111 or other emergency services) directly accessing the ambulance control despatch system.

327. **See, treat and convey:** the unit of payment is per incident.

- The number of incidents – following emergency or urgent calls – where at least one patient is conveyed by ambulance despatched vehicle to an alternative healthcare provider.
- Alternative healthcare provider includes any other provider that can accept ambulance patients, such as A&E, urgent treatment centres, walk-in centre, major trauma centre, independent provider, etc.
- Include incidents despatched by third parties (such as 111 or other emergency services) directly accessing the ambulance control despatch system.
- Exclude patient transport services and other contracts with non-NHS providers. To avoid doubt, activity included within a designated patient transport service or other subcontract activity is excluded.

328. When considering local prices for ambulance services, providers and commissioners may wish to consider how they would support the ambitions set out in the NHS Long Term Plan and Lord Carter's *Review of operational productivity and performance in English NHS ambulance trusts: unwarranted variation*.[45]

[45] https://improvement.nhs.uk/about-us/corporate-publications/publications/lord-carters-review-unwarranted-variation-nhs-ambulance-trusts/

329. The following questions can be used to help inform local pricing if commissioners and providers want to vary or adopt a different currency from that recommended above:

- How would the variation support a safe reduction in avoidable conveyance of patients to Type 1 or Type 2 emergency departments – for example, through incentivising hear and treat and see and treat responses or diversion of calls to an appropriate provider where clinically appropriate?
- How would diversion of calls to an appropriate provider or hear and treat and see and treat responses be incentivised financially?
- How would conveyance to alternative healthcare settings such as urgent treatment centres and assessment and ambulatory care wards be incentivised, where possible and appropriate?
- How would the variation take account of job cycle time, recognising that some see and treat incidents may take longer than some see, treat and convey incidents?
- How would the variation have due regard to any future service reconfigurations and integrations with other service providers that may impact on the ambulance service, or new approaches to reimbursement elsewhere in the national tariff, such as ‘blended payments’ for non-elective admissions and A&E attendances? The implementation of service reconfigurations may impact on job cycle times and require a different skill set in clinical staff which will need to be considered in any alternative payment approach.
- Has the financial impact across the system been considered? For example, additional investment in one service area could help to realise savings elsewhere in the local health system.
- Does the variation appropriately recognise that the overriding priority remains the delivery of a safe, effective and sustainable ambulance service which ensures that patients receive the care they need?

330. We will consider reviewing the current ambulance currencies and developing benchmark information to aid local pricing discussions.

17 Wheelchair currencies

331. The currencies for wheelchair services were introduced in April 2017. Providers were already reporting against these currencies to support commissioners to submit quarterly returns to NHS England. There are plans to develop regular and more granular data collections for wheelchair services, such as potentially including wheelchair information in a future version of the Community Services Dataset.

332. The currencies are based on a number of components. They are categorised by service user needs and wheelchair type within an episode of care. The currencies cover assessment and review, provision of equipment, and repair and maintenance. The data definitions and examples of each category are explained in Table 19.

333. These services do not have unit prices calculated using the method for national and unit prices in Section 6 of the 21/22 NTPS. However, we have determined and published non-mandatory benchmark prices for children and adult wheelchair services in the *Non-mandatory guide prices* workbook. These prices are based on reported reference costs and can be used as a starting point for conversations about local prices.

334. For 2021/22 the wheelchairs currencies have been updated. This followed a review by the NHS England and NHS Improvement Pricing Team, working with colleagues in the Personalised Care Group, as well as commissioners and providers of wheelchair services. Building on the feedback from a wide range of stakeholders we therefore developed currencies which fit into four categories:

- Assessment of needs
- Provision of equipment
- Wheelchair user review
- Repair and maintenance

335. The following sections summarise each currency.

17.1 Assessment of Needs

336. The assessment process is used to understand a patient's needs. This enables the wheelchair service to determine what type of wheelchair and additional accessories a patient will require to ensure they are able to do what is most important to them.

337. There are four levels of patient need; low, medium, high and specialised. For the high and specialised categories, a user may be assessed for a manual or powered wheelchair. This provides six clearly defined currencies:

- Assessment – low need
- Assessment – medium need
- Assessment – high need – manual wheelchair
- Assessment – high need – powered wheelchair
- Assessment – specialised need – manual wheelchair
- Assessment – specialised need – powered wheelchair

Assessment – Low Need (WC01)

- Limited need allocation of clinical time.
- Occasional users of wheelchair with relatively simple needs that can be readily met.
- Do not have postural or special seating needs.
- Physical condition is stable, or not expected to change significantly.
- Assessment does not typically require specialist staff (generally self-assessment or telephone triage supported by health / social care professional or technician).
- Limited (or no) requirement for continued follow up / review.

Assessment – Medium Need (WC02)

- Higher allocation of clinical time than low need, including the use of more specialist time with Face to face or video assessment for a manual wheelchair.
- Daily users of wheelchair or use for significant periods most days.
- Have some postural or seating needs.
- Physical condition may be expected to change (e.g. weight gain / loss; some degenerative conditions)
- Comprehensive, holistic assessment by skilled assessor required.
- Regular follow up / review

Assessment – High Need – Manual (WC03)

- This currency involves a higher allocation of clinical time than the medium currency.
- Comprehensive, holistic assessment by skilled assessor requiring the use of a higher and more specialist skillset of staff.
- Permanent users who are fully dependent on their wheelchair for all mobility needs.
- Physical condition may be expected to change / degenerate over time.
- Very active users, requiring equipment to maintain high level of independence.
- Complex postural or seating requirements or pressure care (e.g. for high levels of physical deformity).
- Regular follow up / review with frequent adjustment required / expected.

Assessment – High Need – Powered (WC04)

- This currency involves a higher allocation of clinical time than the medium and high need – manual currencies.
- Comprehensive, holistic assessment by skilled assessor requiring the use of a higher and more specialist skillset of staff.
- Permanent users who are fully dependent on their wheelchair for all mobility needs.
- Physical condition may be expected to change / degenerate over time.
- Active users, requiring powered mobility to retain independence and active lifestyle.
- Complex postural or seating requirements or pressure care (e.g. for high levels of physical deformity).
- Regular follow up / review with frequent adjustment required / expected.

Assessment – Specialised Need – Manual (WC15)

- This currency involves a higher allocation of clinical time than the high need-currencies.
- Comprehensive, holistic assessment by highly skilled and experienced assessor or team required. It may also include the need for specialist suppliers in the assessment process.
- Permanent users who are fully dependent on their wheelchair for all mobility needs.
- Highly complex postural or seating requirements or pressure care.

- Physical condition will be expected to change / degenerate over time.
- Regular re-assessment with frequent adjustment required / expected.

338. Wheelchair users requiring a specialised needs assessment are expected to present with one of the following:

- Physical condition will be expected to change / degenerate over time.
- Have complex and /or fluctuating medical conditions and multiple disabilities, which may include physical, cognitive, sensory and learning aspects.
- They are likely to require 24 hour postural management due to; poor trunk control, inability to sit without support, limited upper limb function, possible spinal curvature and joint contractures.
- They are at high risk of secondary complications due to their levels of disability such as contractures, chest infections and respiratory diseases.
- The most common diagnoses for people who need specialist wheelchairs are: cerebral palsy, muscular dystrophy, multiple sclerosis, brain injury, motor neurone disease, high level spinal cord injuries.

Assessment – Specialised Need – Powered (WC16)

- This currency involves a higher allocation of clinical time than the specialised need – manual currencies.
- Comprehensive, holistic assessment by highly skilled and experienced assessor or team required. It may also include the need for specialist suppliers in the assessment process.
- Permanent users who are fully dependent on their wheelchair for all mobility needs.
- Highly complex postural or seating requirements or pressure care.
- Physical condition will be expected to change / degenerate over time. Regular re-assessment with frequent adjustment required / expected.

339. Wheelchair users requiring a specialised needs assessment are expected to present with one of the following:

- Physical condition will be expected to change / degenerate over time.
- Have complex and /or fluctuating medical conditions and multiple disabilities, which may include physical, cognitive, sensory and learning aspects.

- They are likely to require 24-hour postural management due to; poor trunk control, inability to sit without support, limited upper limb function, possible spinal curvature and joint contractures.
- They are at high risk of secondary complications due to their levels of disability such as contractures, chest infections and respiratory diseases.
- The most common diagnoses for people who need specialist wheelchairs are: cerebral palsy, muscular dystrophy, multiple sclerosis, brain injury, motor neurone disease, high level spinal cord injuries.

17.2 Provision of Equipment

The provision of equipment currencies can be split into two separate sections:

- provision of a wheelchair
- provision of corresponding equipment and accessories to meet the needs of the wheelchair user.

The provision of wheelchair currencies are:

- Wheelchair Package – low
- Wheelchair Package – medium
- Wheelchair Package – high (manual wheelchair)
- Wheelchair Package – high (powered wheelchair)
- Wheelchair Package – specialised (manual wheelchair)
- Wheelchair Package – specialised (powered wheelchair)

Additional equipment and accessories can be provided for a wheelchair user's current wheelchair to ensure it meets their needs. These currencies will apply when a user's wheelchair is able to meet their needs with the addition of some accessories or modifications

- Accessories – low
- Accessories – medium
- Accessories – high
- Accessories – specialised
- Accessories – specialised with specialised seating

It is important to note that a user's assessment and provision of equipment category may differ. For example, a patient may be assessed for a powered wheelchair, but

during the assessment process it is agreed that a powered wheelchair would not be right for that person and a manual wheelchair should be provided.

Additionally, some patients may require aspects of one currency with elements of a higher level currency. Where this is the case, the higher level currency will be allocated to the provision of equipment of r this patient. For example, if a patient was to require a lightweight wheelchair (Wheelchair Package – medium) and a high pressure relieving cushion (Accessories – high). This would result in a Package of care - high currency due to the inclusion of the higher need cushion.

Provision of wheelchair

Wheelchair Package – Low (WC05)

- Non-modular wheelchair (self or attendant-propelled).

- Standard cushion.
- Up to 1x accessory.
- Up to 1x modification.

Wheelchair Package – Medium (WC06)

- Configurable, lightweight or modular wheelchair (self-or attendant propelled).
- Entry level buggies.

- Low to medium pressure relieving cushions.
- Up to 2x accessories.
- Up to 2x modifications.

Wheelchair Package – High Need – Manual Mobility (WC07)

- Highly modular manual wheelchairs.
- High efficiency fixed frame wheelchairs, ultra-light weight wheelchairs.
- Specialist buggies.

- High pressure relieving cushions.
- Up to 3x accessories.
- Up to 3x modifications.
- Customised equipment.

Wheelchair Package – High Need - Powered Mobility (WC08)

- Powered wheelchairs with standard features.

- High pressure relieving cushions.
- Up to 3x accessories.

- Up to 3x modifications.
- Customised equipment.

Wheelchair Package – Specialist Need – Manual Mobility (WC17)

- Tilt in space modular wheelchairs.
- Complex manual wheelchairs with integrated seating systems.
- Highly specialist bespoke buggies.

- Seating systems on different manual chassis.
- 4 or more accessories.
- 4 or more modifications.
- Highly complex bespoke modifications.

Wheelchair Package – Specialist Need – Powered Mobility (WC18)

- Complex powered equipment with specialist powered features.

- Seating systems on powered wheelbases.
- 4 or more accessories.
- 4 or more modifications.
- Complex bespoke modifications.
- Specialist control systems.
- Powered wheelchair controllers that require Integration with other assistive technology.

Provision of accessories

Accessories – Low (WC19)

Items for a Non-modular wheelchair (self or attendant-propelled).

- Standard cushion.
- Up to 1x accessory.
- Up to 1x modification.

Accessories – Medium (WC20)

Items for –

- **Lightweight or modular wheelchair (self or attendant-propelled).**
- **Entry level buggies.**

- Low to medium pressure relieving cushions.
- Up to 2x accessories.
- Up to 2x modifications.

Accessories – High (WC21)

Items for -

- **highly modular manual wheelchair, high efficiency fixed frame wheelchairs, ultra-light weight wheelchairs**
- **powered wheelchair with standard features.**
- **specialist buggy.**

- High pressure relieving cushions.
- Up to 3x accessories.
- Up to 3x modifications.
- Customised equipment.

Accessories – Specialist (WC22)

Items for -

- **complex manual wheelchair with or without an integrated seating system, tilt in space modular wheelchairs**
- **complex powered equipment with specialist powered features and with or without an integrated seating system.**
- **highly specialist bespoke buggy.**

- 4 or more accessories.
- 4 or more modifications.
- Highly complex bespoke modifications.

Accessories – Specialist with Specialised Seating (WC23)

Items for -

- **complex manual wheelchair with or without an integrated seating system, tilt in space modular wheelchairs**
- **complex powered equipment with specialist powered features and with or without an integrated seating system.**
- **highly specialist bespoke buggy.**

- Seating systems on different manual chassis.
- 4 or more accessories.
- 4 or more modifications.
- Highly complex bespoke modifications.

This currency includes the provision of a specialised seating system provided by a specialist provider and the fitting of this seating system on a user's existing wheelchair. If specialist accessories and/or modifications are required without the need for a new specialised seating system then currency WC22 should be applied.

17.3 Review

Review (WC11)

There is a single currency under the review category – WC11. The review involves a wheelchair user who already has existing equipment and does not require a new package of care.

A review offers a way for the service to consider a patient's care at a point in time after a wheelchair has been provided. A review could be initiated by a change in the patients' condition or requirements and could be planned or referred via an emergency route.

If a user requires a new wheelchair or additional/replacement parts as a result of the review, the patient will be assessed with the appropriate assessment currencies allocated. This will be under a new episode of care.

A review resulting in an onward referral to repair and maintenance will incur the standard review currency.

A user re-entering the service could initially be considered to have a review. However, if it is ascertained via this review that the user requires further intervention which may result in a major change, a new episode of care will be recorded as an assessment.

Not all services are commissioned to provide a review.

17.4 Repair and Maintenance

The repair and maintenance currencies cover the time and resources associated with ensuring that a wheelchair is in good condition and remains fit for purpose.

The currencies include:

- Parts and labour for repair of wheelchairs;
- Delivery or collection of wheelchairs to or from users;

- Costs associated with scrapping wheelchairs at the end of their useful lifecycle
- Annual planned preventative maintenance.

Due to the relative complexity of manual and powered wheelchairs, there are two separate currencies:

- Manual Repair and Maintenance (WC09)
- Powered Repair and Maintenance (WC10)

Repair and Maintenance – Manual (WC09)

The annual upkeep and repair of a manual wheelchair currently in use. This currency includes the cost of:

- Parts and labour for repair of wheelchairs.
- Delivery or collection of wheelchairs to or from users.
- Costs associated with scrapping wheelchairs at the end of their useful lifecycle.
- Annual planned preventative maintenance for manual wheelchair users.

Repair and Maintenance – Powered (WC10)

The annual upkeep and repair of a powered wheelchair currently in use. This currency includes the cost of:

- Parts and labour for repair of wheelchairs.
- Delivery or collection of wheelchairs to or from users.
- Costs associated with scrapping wheelchairs at the end of their useful lifecycle.
- Annual planned preventative maintenance for power wheelchair users.

18 Spinal cord injury services

340. Acute spinal cord injury (SCI) is a traumatic event that results in disturbances to normal sensory, motor or autonomic function and ultimately affects a patient's physical, psychological and social wellbeing. There are eight specialised spinal cord injury centres in England that provide an extensive range of medical and allied health services to patients, not only those that are obviously related to the spine.

341. The specialised spinal cord injury service provides not only care following injury, which usually lasts many months, but life-long care for patients living with spinal cord injury. In people with no sensation below the level of injury, the body learns to function in unusual ways. Illness can go undiagnosed, and problems that would not be serious in another patient can become life-threatening.

18.1 The currency model

342. In collaboration with all the SCI centres (SCICs), a clinical pathway, based on the multiple episodes of care a patient may experience on their journey, has been developed and tested.

343. SCI centres treat newly injured patients in the acute stage following their injury, as well as provide rehabilitation to newly injured patients and to some patients whose paralysis results from non-traumatic causes. This will be followed up by the lifelong care of patients living with spinal cord injury.

344. Four key activities in the patient pathway have been identified:

- pre-admission
- initial admission
- post-discharge
- readmission.

345. Patients may arrive at the SCICs at many different points along the pathway but principally at pre-admission, where a neurological assessment will take place to

understand the patient's suitability for a referral to the SCI unit. During this period, perhaps in a trauma centre, SCI centres may despatch an outreach team to assess the patient's suitability for transfer to the SCI or consider the patient's needs by means of a case conference.

346. The initial admission stage covers the admission to the SCI, mobilisation and preparation for rehabilitation through to discharge. For the purposes of this pathway rehabilitation, packages begin when the patient is:

- able to sit up in a wheelchair for four hours
- **and** fit for rehabilitation
- **and** has
  - **either** been weaned (if previously ventilated)
  - **or** has ventilation requirements which permit full participation in rehabilitation.

347. Patients may be readmitted for complications resulting directly from their spinal cord injury, most frequently for urological problems. They may also be admitted for the management of unrelated conditions because other services are not geared up to provide the specialised facilities and nursing they require.

348. The National Spinal Cord Injury Database was mandated as part of the service specification and went live in July 2013.

349. The database contains all the necessary data points for identifying the packages of care within the pathway. Patient complexity has been incorporated into the database so future enhancements to the currencies can be made.

350. Further work is taking place to identify the cost breakdown of these services and where unbundling from the spinal cord injury service is required: ie spinal surgery, urology, tissue viability, plastic surgery, fertility, etc). This will provide greater consistency and transparency of service delivery across all sites.

19 Adult mental health services

351. Mental ill-health is the most common cause of disability in the UK. Each year, one in four adults suffer from a mental health condition. Mental health services for adults cover a broad range of conditions. The services to treat and manage each condition can vary considerably across the country. This can reflect historic differences in investment as well as differences in clinical practice between providers.

19.1 Services for working age adults and older people

352. Mental health clusters are the underpinning currencies for mental health services for adults and older people. Clusters group people according to their needs under three broad diagnostic categories – psychotic, non-psychotic and organic. They provide a framework for planning and organising mental health services and the care and support provided to individuals. There are 21 clusters (see Table 19). Each patient is assessed based on their symptoms and individual need. The clusters allow for a degree of variation in the combination and severity of rated needs. For more details of the clusters, see Annex D: Mental health clustering tool.

Table 19: Mental health care cluster currencies

Care cluster	Description
0	Variance cluster
1	Common mental health problems (low severity)
2	Common mental health problems (low severity with greater need)
3	Non-psychotic (moderate severity)
4	Non-psychotic (severe)
5	Non-psychotic (very severe)
6	Non-psychotic disorders of over-valued ideas
7	Enduring non-psychotic disorders (high disability)
8	Non-psychotic disorders (high disability)

Care cluster	Description
9	Blank cluster
10	First episode psychosis
11	Ongoing recurrent psychosis (low symptoms)
12	Ongoing recurrent psychosis (high disability)
13	Ongoing recurrent psychosis (low symptoms)
14	Psychotic crisis
15	Severe psychotic depression
16	Dual diagnosis
17	Psychosis and effective disorder-difficult to engage
18	Cognitive impairment (low need)
19	Cognitive impairment or dementia complicated (moderate need)
20	Cognitive impairment or dementia complicated (high need)
21	Cognitive impairment or dementia complicated (high physical or engagement)

19.2 IAPT services

97. Improving Access to Psychological Therapies (IAPT) is an evidence-based stand-alone package of care provided to people with mild to moderate mental health problems. Patients can self-refer to IAPT services and may also be referred directly by their GP. IAPT practitioners use the mental health clustering tool to help identify the acuity of patients who are being seen in services, and when patients should be referred to secondary care.

98. Costs are submitted on the basis of the identified cluster, which also forms the currency model for IAPT services.

99. Most people in receipt of IAPT will not be in receipt of any other mental health care. A particular feature of the IAPT model is the collection and submission by clinicians of data related to a nationally determined set of outcomes, including measures of clinical improvement, to the IAPT dataset.

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