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2025/26 NHS Payment Scheme – a consultation notice

Annex DpB: Guidance on currencies

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Contents

1. Introduction

1. This document is Annex DpB of the consultation on proposals for the 2025/26 NHS Payment Scheme (NHSPS). It is proposed that this document would, as an annex, form part of the 2025/26 NHSPS on publication.

2. A currency is a way of grouping patients or activities into units that are clinically similar and have broadly similar resource needs and costs. Each unit of currency must be evidence-based and analytically identifiable, but most importantly it must be clinically meaningful. The currency must be rooted to the care the patient receives and be practical to implement. A currency can be used to support payment by providing a standardised methodology for classification of clinical casemix and understanding a patient and their care needs.

3. Multiple currency units can be grouped into currency models which cover a patient population, care service or condition A currency can take many different forms; for example, it could involve:

   - a bundle of services for a group of patients
   - a particular population
   - an individual episode of treatment
   - specific attributes such as needs (for example, the mental health and community currency models, as detailed in the currency guidance supporting documents).

4. Under the amended 2012 Act, the NHSPS rules may set prices for individual services or units, but the rules may also provide for prices to be determined by reference to groups of services. So, for example, the NHSPS aligned payment and incentive (API) rules provide for a price to be calculated for a group of secondary care services provided throughout a financial year. But currencies for individual services and units of healthcare (or bundles of services) continue to be relevant, for example because they are the basis of activity-based payment rules or are used to calculate the API variable element.

5. For services with NHSPS prices, casemix groupings (healthcare resource groups – HRGs) are used as the currency for admitted patients, outpatient procedures and A&E. For outpatient attendances, the currency (treatment function codes – TFCs) is based on groupings that relate to clinical specialty and attendance type (eg first or follow-up attendance). 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'.

6. The HRG currency design used for the 2025/26 NHSPS prices is HRG4+ phase 3. HRG4+ is arranged into chapters, each covering a group of similar conditions or treatments. Some chapters are divided into subchapters. The specific design for the 2025/26 NHSPS is that used to collect 2018/19 reference costs.

7. The currencies for outpatient attendances are counted based on coding to identify clinical specialty and attendance type, defined by TFC.

8. Each unit of activity delivered will be grouped to a currency, based on the diagnosis and treatment codes. For example, outpatient procedures would be grouped to either HRG or TFC prices:

    - Where the activity involves a procedure that is grouped to an HRG with an outpatient procedure price, that is the price used.
    - Where the activity does not include a procedure with an outpatient procedure price, this should group to the attendance TFC, which would be the price paid.

9. This document contains details of currencies for individual services. This includes currencies:

    - with unit prices (published in Annex DpA for use in the API variable element and activity-based payments)
    - with guide prices (published in Annex DpA, to be used to support local payment arrangements)
    - without payment scheme prices
    - for community and mental health care.

10. As well as being used for payment, currencies are used to collect costs on a consistent basis as part of the National Cost Collection.

1.1 Overview of currencies in this annex

Currencies with unit prices

- Admitted patient care
- Outpatient attendances
- Diagnostic imaging
- Chemotherapy and radiotherapy

- Nuclear medicine
- Direct access
- Post-discharge rehabilitation
- Cystic fibrosis pathway payment
- Looked-after children health assessment

Currencies with guide prices

- A&E services
- Maternity pathways
- Critical care (adult, paediatric and neonatal)
- Renal dialysis for acute kidney injury
- Renal transplant
- Cardiothoracic transplantation
- Bone marrow and peripheral blood stem cell transplant
- Specialist rehabilitation

Currencies with no NHSPS prices

- HIV adult outpatient services pathway
- Ambulance services
- Wheelchair currencies
- Spinal cord injury services

Currencies for Community and Mental Health Care

- Mental Health and Neurodevelopmental Resource Groups (MHNRGs)
- Community Currency Models

Currencies with NHS Payment Scheme unit prices

The currencies in this section have unit prices published in Annex DpA of the NHSPS. Unit prices are used for the variable element of aligned payment and incentive arrangements, and for activity-based payments. Prices are paid for services delivered, up to a planned level of activity.

2. Admitted patient care and outpatient procedures

2.1 Admitted patient care and outpatient procedures

11. 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, meaning a single spell had multiple FCEs.

12. When a patient has more than one distinct admission on the same day (calendar day, not 24-hour period: 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.

13. 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.

14. The costs of some elements of the care pathway, such as critical care and high cost drugs, are excluded from unit prices.

15. 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.

16. 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 to reflect the required resources to deliver care to patients.

17. The 2023/25 NHSPS made some changes to the admitted patient care and outpatient procedure prices for abortion (also known as termination of pregnancy) services. The approach to the calculation of these prices has continued for 2025/26, although please note that the default payment mechanism for these services in 2025/26 is a variable payment. Section 2.2 describes the rationale and details for abortion services in greater detail.

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

19. Prior to the 2021/22 National Tariff, and the shift to API for almost all services, short stay emergency (SSEM) adjustments would apply to national currencies and national prices for admitted patient care. However, in the NHSPS, SSEM adjustments should only be applied where relevant prices are used. See Annex DpD for details of SSEM.

Long-stay payment

20. For patients who remain in hospital beyond an expected length of stay for clinical reasons, there is a reimbursement in addition to the 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 and point of delivery. 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.

21. The trim point is spell based and there are separate elective and non-elective trim points. The trim point for each HRG is shown alongside prices in Annex DpA.

22. For simplicity, there is a trim point floor of five days for all HRGs in Annex DpA, regardless of whether the HRG includes length of stay logic of less than five days. There are two long-stay payment rates per chapter – one for child-specific HRGs and one for all other HRGs.

23. 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 discharge ready date and actual discharge date from any long-stay payment. The commissioner is not liable for any long-stay payment for those days, however the Community Care (Delayed Discharges etc) Act 2003 has been repealed by the Health and Care Act 2022 and so delayed discharge payments for those days can no longer be imposed on local authorities either.

2.2 Termination of pregnancy services

24. Abortion (also known as termination of pregnancy) is one of the most common procedures in the NHS and demand has risen rapidly, up 17% compared to the previous year. At the same time, the sector is experiencing declining NHS capacity, resilience challenges and workforce constraints. This is impacting patients, with unmet need for surgical services, significant travel distances at later gestations and constrained access. Providers report wait times for surgical abortions often being three weeks or longer (against a NICE standard of two weeks) impacting on patient care and increasing clinical risk of procedures.

25. In response to this, in March 2024, NHS England published the NHS vision for abortion services which highlights the need for the NHSPS to promote sustainability for both

independent and NHS providers. It also recognises the need to increase NHS capacity alongside independent provider capacity, particularly in relation to surgical abortions. NHS capacity is required to contribute to overall increases in capacity across the abortion sector in response to rising and unmet needs, ensure local resilience, and to enable continuity of safe, viable and high-quality abortion and miscarriage management services. NHS capacity is also essential to deliver certain services that are not possible to provide in the independent sector (eg due to complexity or clinical risk). Additionally, NHS providers have a key role in training the current and future workforce, with NHS capacity supporting and enabling opportunities for abortion care training and skills development.

26. To begin to increase surgical abortion capacity to reduce wait times to meet the NICE standards for wait times, commissioning guidance is expected to ask ICBs to stabilise NHS capacity in 2025/26 and support increases where possible, and plan for growth of overall surgical capacity in trusts as well as independent providers. NHS England will work with ICBs to develop guidance and metrics to support commissioners and help deliver the NHS vision for abortion services.

27. ICBs should continue to ensure that contracts are sustainable and follow the guidance set out here.

28. To improve service sustainability and capacity, and to complement the ask for ICBs to stabilise NHS capacity, in the 2025/26 NHSPS abortion services will be reimbursed by variable payment, rather than being covered by the fixed element. This change to variable payments will create a direct link between activity levels and payment. This removes a potential financial barrier for NHS providers, where increasing activity could create unfunded costs, while ensuring providers who deliver less than the planned level of activity are not inappropriately compensated.

29. Variable payment for NHS providers covers the core spell for all terminations, including for women with complex comorbidities, as set out in the NHSE Specialised Commissioning service specification. However, it does not include the additional top-up funding for the specialist centres which will be managed by ICBs from April 2025 (with management by NHSE Specialised Commissioning regional teams and ICBs prior to this).

30. For all abortion services provided by both NHS and independent providers, the underlying currencies for termination of pregnancies are part of the HRGs subchapter MA: Female Reproductive System Procedures. These are procedure-specific HRGs for abortion and miscarriages and are differentiated based on medical versus surgical care. Splits are by elective and non-elective care and each currency covers case mix

for medical abortions and for surgical abortions at different gestations. Prices for these currencies are published in Annex DpA.

31. These prices sit alongside other pathway components, including outpatient consultation activities including first attendance and follow-ups, usually coded to TFC 502 – Gynaecology Service, and ultrasound scans. Other activity costs, including STI testing, contraception provision (except where listed in HRGs), and patient travel are not captured within abortion HRGs and are subject to local agreement.

32. Commissioners should continue to take additional care that pricing agreements cover the scope or variety of services requested in the contract, and that prices allow for investment in capacity growth, particularly for surgical services, to reduce waits, improve access, reduce patient travel and meet NICE standards. Pricing agreements should take account of whole pathway prices, including consultations, scans, follow ups and other activities, as well as adjusting for the MFF at the site of treatment.

33. Activity-based payment rules allow providers and commissioners to locally agree to vary away from unit prices where this is appropriate. This applies to both independent and NHS providers. When negotiating contract values for abortion services, providers and commissioners should agree arrangements that consider the measures necessary to ensure the service is safe and sustainable. This should include consideration of service performance and timely access, incorporating NICE standards to deliver an assessment within one week of the request and provide the abortion within one week of the assessment, including for surgical and later gestation medical procedures.

3. Outpatient attendances

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

35. Separate 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.

36. Under NHSPS rules for outpatient services delivered by NHS providers:

- first attendances would be covered by the API elective variable rate.
- outpatient follow-ups would be covered by the API fixed element.

37. All outpatient attendances delivered by non-NHS providers would be covered by the activity-based payment mechanisms.

3.1 Consultant-led and non-consultant led

38. The NHS Data Model and Dictionary definition 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”.

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

3.2 First and follow-up attendances

40. 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.

41. 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.

42. 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 costs reported in the patient-level cost data (PLICS) 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 DpA.

43. For those that want to use prices without frontloading, as more cost-reflective prices, we have calculated a set of non-frontloaded guide prices, published in Annex DpA.

44. 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.

45. Where new models of care are being developed which involve combining outpatient first, follow up and diagnostic activity in the same patient visit – sometimes referred to as ‘one stop shops’ – providers and commissioners should adhere to the principle that the payment mechanism shouldn't financially disincentivise this care model. This might mean ensuring, in the first instance, that the provider is paid as they would be under the old model of care. This may be particularly important for some cancer diagnostic referrals, including, one stop activity models relating to breast cancer diagnosis activity.

46. 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

47. Annex DpA contains separate 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
- X62.3: assessment by multidisciplinary team not elsewhere classified for multidisciplinary consultations.

48. 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.

49. 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.

50. 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.

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

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

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

54. 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.

55. 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

56. There are separate HRGs for face-to-face and non-face-to-face attendances, derived from the information recorded in "First attendance" or "First attendance code".

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

58. The 2020/21 National Tariff set non-mandatory prices for non-face-to-face outpatient attendances, based on a subset of activity reported in 2016/17 reference costs. However, these prices were not published after 2021/22 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 API 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 API agreements to support the most appropriate method of delivering care.

59. Where local agreement on prices for non-face-to-face activity is not possible, the 2020/21 National tariff non-mandatory prices should be used. 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 National Tariff and **should not be used for any payment mechanism in the NHSPS**.

60. Advice and guidance and specialist advice services are different to non-face to face outpatient activities and reimbursement for these should be agreed as part of the API agreement. This asks providers and commissioners to agree a fixed payment to deliver an agreed level of service, with a locally agreed variable payment for use if demand on the service is higher or lower than expected.

4. Diagnostic imaging

61. The currency for diagnostic imaging covers diagnostic imaging for patients of all ages, undertaken in admitted or non-admitted care settings. All but two of the HRGs in this subchapter are unbundled (ie treated separately to the core HRGs that reflect the primary reason for a patient admission or treatment; unbundled HRGs better describe the elements of care that comprise the patient pathway and can be commissioned, priced and paid for individually).

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

- magnetic resonance imaging scans
- computed tomography scans
- dual energy X-ray absorptiometry (DEXA) scans
- contrast fluoroscopy procedures
- non-obstetric ultrasounds
- simple echocardiograms.

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

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

Where diagnostic imaging costs remain included in unit prices

65. Diagnostic imaging does not attract a separate price in the following instances:

- where the patient data groups to a procedure-driven HRG that would be covered by an aligned payment and incentive agreement (that is, not from HRG4+ subchapter WF)
- where the unit price is zero (eg LA97A, SB97Z and SC97Z, which relate only to the delivery of renal dialysis, chemotherapy or external beam radiotherapy), any diagnostic imaging is assumed to be connected to the outpatient attendance
- where diagnostic imaging is carried out during an admitted patient care episode or during an A&E attendance
- where imaging is part of a price for a pathway or year of care (eg the best practice tariff for early inflammatory arthritis)
- where imaging is part of a specified service for which a unit price has not been published (eg cleft lip and palate).

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

Processing diagnostic imaging data

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

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

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

70. National clinical coding guidance, both for the OPCS-4 codes and their sequencing, must be followed. More than one HRG for diagnostic imaging will be generated where more than one scan has been done, and each HRG will attract a separate price. However, where a patient has a scan of multiple body areas under the same modality, this should be recorded using OPCS-4 codes to indicate the number of body areas and will result in one HRG that reflects the number of body areas involved. This means you would not generally expect more than one HRG for any one given modality (eg MRI) on the same day. Please note: The MRI and Cardiac devices steering group have advised that providers funded using prices for undertaking an MRI scan with pre- and post-scan device checks for cardiac devices are sometimes reimbursed at a level below the costs they incur. Where this happens, we recommend that providers and commissioners

discuss this as part of their payment arrangements or use the option to agree a local price where this would be appropriate locally.

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

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

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

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

74. If there is a practical reason why it is difficult to submit the diagnostic imaging record as part of an outpatient attendance record – for example, because the scan happens after the flex-and-freeze date for SUS relevant to the outpatient attendance – we recommend a pragmatic approach. For example, the scan could be submitted as for a direct access scan, using a dummy outpatient attendance of TFC 812 Diagnostic Imaging to ensure that no double payment is made for the outpatient attendance.

5. Chemotherapy and radiotherapy

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

5.1 Chemotherapy delivery

76. HRG subchapter SB covers both the procurement and the delivery of chemotherapy for patients of all ages. The HRGs in this subchapter are unbundled (ie treated separately to the core HRGs that reflect the primary reason for a patient admission or treatment; unbundled HRGs better describe the elements of care that comprise the patient pathway and can be commissioned, priced and paid for individually). They include activity undertaken in inpatient, day-case and non-admitted care settings.

77. 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.

78. From 2020/21, the procurement HRGs are no longer in use and there is no requirement to collect data on them. We are continuing to work with NHS England Specialised Commissioning to support all providers to move to pass through and in-year block payments for chemotherapy drugs and treatments. with data reported via the monthly Drug Patient Level Contract Monitoring return (DrPLCM).

79. As almost all specialised services are in scope of API, local pricing and payment arrangements do not apply for these services.

80. Funding for specified high cost drugs (see Annex DpA, tab 12b) should be included in the API fixed element. Some other high cost drugs and Cancer Drugs Fund drugs continue to be paid outside of the NHSPS. For more details, see Section 3.4 of the NHSPS.

81. The current 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 an NHSPS price. The price for SB17Z will continue to be locally negotiated.

82. The current chemotherapy delivery HRGs are dependent on the chemotherapy regimen list which, due to new treatment options and combination therapies, has not been updated since 2017/18. This means that more and more treatments are defaulting

to SB17Z. We will be working with the Chemotherapy Costing Expert Working Group (CEWG), the National Casemix Office and NHS England Specialised Commissioning to develop a revised currency that reflects modern practice and treatments.

83. Chemotherapy reimbursement should use the NHSPS unit prices (with MFF applied). Providers and commissioners should agree a local price for SB17Z which reflects the local casemix.

84. The cost of the delivery HRGs includes the cost of supportive drugs listed on the NHS England chemotherapy supportive drugs list. This should support a consistent basis for reimbursement and remove the need to report costs at an individual patient level. The cost of supportive drugs should also be included in the local price for SB17Z.

Table 1: Current 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.

Table 2: Counting arrangements for chemotherapy HRGs

	Core HRG	Unbundled chemotherapy delivery HRG

Ordinary admission	eg LB35C 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 LB35C	eg SB14Z Unit prices
Regular day and regular night admissions	As per day case and outpatient	eg SB14Z Unit prices

85. 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).

86. 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.

87. Please note: NHSPS prices do not cover reimbursement for the cost of aseptic units. Funding is included within the API fixed element.

5.2 Radiotherapy

88. The NHS Long Term Plan (LTP) included a commitment to review the payment arrangements for radiotherapy, in particular to ensure that appropriate incentives are in place to encourage providers to increase access to new treatments and techniques and to upgrade and replace equipment. While this work has been delayed, due to the unique circumstances of the pandemic, it has remained a key priority.

89. The way that radiotherapy care is being delivered is changing with more patients being treated with Intensity Modulated Radiation Therapy (IMRT) and some patients being treated with the same radiation dose but over fewer fractions (known as hypofractionation). There has also been the introduction of new techniques such as

Stereotactic ablative radiotherapy (SABR) and Stereotactic radiosurgery/therapy (SRS/T).

5.2.1 Development of radiotherapy services

90. The current range of radiotherapy HRGs do not cover the newer techniques and the NHSPS prices will also need to be updated to take account of changes in clinical practice. We will be working with the National Casemix Office, NHS England Specialised Commissioning and other relevant groups to expand the current HRGs to reflect modern practice and treatments. Unit prices for three types of specialist radiotherapy were introduced in 2024/25 (see Section 5.2.3).

91. Radiotherapy will be included in the fixed element of the API with the starting value based on the uplifted 2023/24 contract value for service lines NCBPS01R: Radiotherapy (adults) and NCBPS51R (children), with a corresponding activity level based on the current set of HRGs which will continue to be used for monitoring activity levels during 2025/26. There will not be an activity-based variable element to reimbursement. There are 2 key reasons for this: to stabilise provider income whilst the HRGs and prices are updated and to mitigate the increasing use of hypofractionation.

92. Funding for agreed levels of activity growth should be added the 2024/25 baseline value and included in the fixed element of the API.

93. It is intended that future payment reform will include a variable quality-based element. This will be developed with the NHS England Specialised Commissioning team and ICSs, with advice from the relevant Cancer Alliance(s) and Radiotherapy Operational Delivery Network. We will work with local cancer systems to identify key quality improvements for which national KPIs can be developed during 2025/26. The intention is to increase the quality-based variable element to c.10% over a number of years.

94. For three specific services – Stereotactic radiosurgery/radiotherapy (SRS/T), Stereotactic Ablative Therapy (SABR), and Selective internal radiation therapy (SIRT) – NHSPS unit prices were introduced in 2024/25 and continue to be applicable for 2025/26. These three specialist services are funded as part of the API variable element.

95. It is expected that the majority of radiotherapy equipment, particularly linear accelerators (linacs), will need to be replaced at 10 years of age, in order to continue to make progress on LTP priorities, including enabling local access to cutting-edge radiotherapy treatments like SABR. The responsibility to plan for radiotherapy equipment replacement resides with ICSs, using their system operational capital allocations. ICSs will therefore need to develop replacement plans as part of their multi-

year capital plans, in partnership with specialised commissioners, Cancer Alliances and Radiotherapy Operational Delivery Networks (ODNs), based on an assessment of equipment age, capacity and demand, opportunities to improve access and service risk.

96. In order to support system capital planning, the revenue cost of capital associated with the key equipment (eg depreciation, capital charges or lease costs) will not be included in future NHSPS benchmark prices. Instead, this will be included as a separate section within the fixed element of the API. During 2025/26, providers and commissioners will need to agree a multi-year schedule of the actual/expected cost of capital for all linacs. The schedule should include the date the linac became operational (or expected to become operational), the expected replacement date, whether the linac is owned or leased, the total number of years of depreciation (expected to be 10) and the actual (or expected) cost of capital for each year. From 2026/27, as part of the overall payment reform for radiotherapy, the value will be deducted from the general fixed element of the API and shown separately. The schedule will need to be updated each year. If a linac, which is still in use, has been fully depreciated and is not being replaced, then the commissioner will withhold the associated funding until it has been replaced. If a linac does not need replacing, then the commissioners, in discussion with the ODNs, will determine how the funding will be used. The first call on funding should be for any additional cost of capital for radiotherapy equipment already invested since the 2026/27 baseline followed by any planned equipment upgrades in the next few years. The current HRGs will still be used to monitor activity while the new HRGs are being developed.

5.2.2 Current radiotherapy HRGs

97. The current 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. 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. 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.

98. 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.

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

- external beam radiotherapy preparation
- external beam radiotherapy delivery
- brachytherapy and molecular radiotherapy administration

100. There are NHSPS prices for external beam radiotherapy.

101. 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.

102. 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 3: Counting 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

103. 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).

104. 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.

105. 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.

106. 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 will attract a price.

5.2.3 Specialist radiotherapy currencies

107. The following types of radiotherapy are currently funded as part of the API variable payment:

- Stereotactic radiosurgery/radiotherapy (SRS/T)
- Stereotactic Ablative Therapy (SABR)
- Selective Internal Radiation Therapy (SIRT)

108. To support delegation to ICBs, unit prices for these services are published in Annex DpA, tab 4.

109. Stereotactic radiosurgery/radiotherapy (SRS/T) are methods of delivering doses of precisely targeted intracranial radiotherapy treatment and used for a wide range of malignant and benign intracranial conditions. Four new local codes for this type of radiotherapy (see Table 4), were introduced for 2024/25, setting unit prices based on commissioner cost data. The service was nationally re-procured during 2024/25.

110. The local codes are based on how the service has historically been funded – ie, on a price per patient dependent on the “tier” of activity being undertaken. There are four tiers, plus paediatrics. Providers should flow data via the ACM using the POD code “POC”: Package of Care and the local HRG codes SRST1 to SRST5. Patient level activity should be reported via the Patient Level Contract Monitoring (PLCM) file as this is not currently available via the Radiotherapy Dataset (RTDS).

111. Stereotactic Ablative Therapy (SABR) is a highly targeted form of radiotherapy which targets a tumour with radiation beams from different angles at the same time. The treatment is delivered in a fewer number of treatments (hypofractionation) than conventional radiotherapy, using one, three, five or eight fractions. Five local codes for

this type of radiotherapy were introduced in 2024/25 (see Table 4). The unbundled radiotherapy also moved to a unit price. This is a package price per patient treated and is based on the standardised local price.

112. The five local codes for SABR are based on the type of SABR being delivered (eg lung). Providers should report activity via the ACM using the unbundled POD of UNBRTHPY (unbundled radiotherapy) and the local HRG codes of SABR1 to SABR 5. If SABR is approved for other cancer types, additional local codes/unit prices will be added and notified to commissioned providers. Patient level data is reported via the RTDS.

113. Selective Internal Radiation Therapy (SIRT) is a type of internal radiotherapy used to control cancers in the liver that can't be removed with surgery. There are four payment parts to SIRT:

- The work up procedure, which groups to HRGs YR54A-C (Percutaneous Transluminal Embolisation of Peripheral Blood Vessel) with unit prices.
- The procedure itself, which groups to HRG YR57Z (Percutaneous, Chemoembolisation or Radioembolisation, of Lesion of Liver) with unit price.
- the cost of the microspheres, which are funded via the specialised services device programme (SSDP).
- unbundled radiotherapy.

114. As part of the implementation of the NICE Technology Appraisal Guidance (TA688), NHS England introduced a standardised local price for the unbundled radiotherapy element (HRG SC28Z – Deliver a Fraction of Interstitial Radiotherapy) in 2021/22. A unit price was introduced in 2024/25, which is a package price per patient treated. Reporting should be via the ACM using the unbundled POD of UNBRTHPY (unbundled radiotherapy) and the local HRG code of SIRT1. No patient level data is required to be submitted as it can be extracted from SUS using the relevant OPCS code.

Table 4: Local codes and currencies for specialist radiotherapy

Local code	Description
SABR1	Stereotactic Ablative Radiotherapy HCC
SABR2	Stereotactic Ablative Radiotherapy Lung
SABR3	Stereotactic Ablative Radiotherapy Oligomets
SABR4	Stereotactic Ablative Radiotherapy Pancreas

Local code	Description
SABR5	Stereotactic Ablative Radiotherapy Re-irradiation
SIRT1	Selective Internal Radiation Therapy
SRST1	Stereotactic Radiosurgery / Stereotactic Radiotherapy Tier 1
SRST2	Stereotactic Radiosurgery / Stereotactic Radiotherapy Tier 2
SRST3	Stereotactic Radiosurgery / Stereotactic Radiotherapy Tier 3
SRST4	Stereotactic Radiosurgery / Stereotactic Radiotherapy Tier 4
SRST5	Stereotactic Radiosurgery / Stereotactic Radiotherapy Paediatrics

115. Due to the nature of external beam radiotherapy and the significant changes required as part of the payment reform, it is recommended that a lead ICB approach is taken.

116. NHS England Specialised Commissioning will publish guidance to accompany the use of the new local codes and prices.

6. Nuclear medicine

117. Nuclear medicine procedures cover both diagnostic and therapeutic nuclear medicine procedures for patients of all ages, undertaken in admitted or non-admitted care settings. All but one of the nuclear medicine HRGs are unbundled (ie treated separately to the core HRGs that reflect the primary reason for a patient admission or treatment; unbundled HRGs better describe the elements of care that comprise the patient pathway and can be commissioned, priced and paid for individually).

118. The prices for the unbundled nuclear medicine HRGs, published in Annex DpA, are separated based on the type of test performed (eg, SPECT-CT, nuclear bone scan, dopamine transporter scan, etc).

119. Two empty core HRGs for nuclear medicine were introduced in the 2016/17 HRG4+ currency design. They are RD97Z (diagnostic imaging) and RN97Z (nuclear medicine that also utilises treatment function code). Empty core HRGs allow a unit price to be paid for each scan. The HRGs are not unbundled. In the 2025/26 NHSPS these two HRGs will continue to have a unit price set at zero for outpatient procedures. This is the same as for other empty core HRGs.

7. Direct access

120. Annex DpA, tabs 3 and 4, 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.

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

122. 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.

123. In the case of direct access diagnostic imaging services for which there are prices, the costs of reporting are included in prices. Annex DpA, 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.

124. There is also an additional guide price for direct access plain film X-rays. See the guide prices tabs in Annex DpA.

8. Post-discharge rehabilitation

125. 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.

126. 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.

127. There are four post-discharge 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 are available in Annex DpA, tab 4, and cover four areas of care:

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

128. There are associated commissioning packs for cardiac rehabilitation and pulmonary rehabilitation.

8.1 Cardiac rehabilitation

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

130. 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.

131. 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.

132. 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.

133. 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.

8.2 Pulmonary rehabilitation

134. 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 2012 Department of Health commissioning pack for chronic obstructive pulmonary disease (COPD). Please also refer to the 2024 NHS England Pulmonary rehabilitation commissioning standards. If the prices are used, commissioners should pay the 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.

135. 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.

8.3 Hip replacement rehabilitation

136. 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.

137. 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.

138. The price therefore represents the funding for this rehabilitation pathway and will act as a maximum level of post-discharge rehabilitation payment.

139. The price should only be applied for patients discharged from acute care with an episode of care with a spell dominant procedure of W371, W381, W391, W931, W941 or W951.

8.4 Knee replacement rehabilitation

140. 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.

141. 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.

142. The price 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 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.

143. The price should be applied 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.

9. Cystic fibrosis pathway

144. 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.

145. 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.

146. 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).

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

148. The care of people with cystic fibrosis is changing due to the introduction of Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) modulators and improvements in nebulized and intravenous antibiotics. The current CF bandings need to be updated to reflect the changes in clinical practice and patient outcomes. We will continue working with both NHS England Specialised Commissioning and ICBs to update the current bandings.

149. CF will be included in the fixed element of the API with the starting value based on the uplifted 2022/23 baseline re-set value for service line NCBPS10Z: Cystic Fibrosis Services, with a corresponding activity level based on the current set of CF bandings which will continue to be used for monitoring activity levels during 2025/26. There will not be an activity-based variable element to reimbursement. There are two key reasons for this: to stabilise provider income whilst the CF bandings and prices are updated and to support service redesign.

150. The pathway 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
- intravenous antibiotics provided during inpatient spells
- annual review investigations.

151. 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.

152. Some elements of services included in the CF pathway may be provided by community services and not the specialist CF centre: for example, 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 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.

153. If the pathway price is used, there some specified services that require further local negotiation:

- 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 CF pathway 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 CF treatment should be covered by the CF pathway. Annual banding should not include the period they spent as an admitted patient receiving their initial surgical management.

154. 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.

10. Looked-after children health assessments

155. Looked-after children (typically children cared for by government – RCPH) 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.

156. 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.

157. 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 commissioner where the child has been placed will have knowledge of and be able to access any local health services required following the health assessment.

158. 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.

159. 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.

160. Prices have been set for children placed out of area. There are also guide prices for health assessments undertaken for children placed in area (see Annex DpA).

161. For more guidance on relevant roles and competences of healthcare staff, see the Royal College of Paediatrics and Child Health web pages: Looked after children (LAC): resources and guidance.

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			

Child's name:			
• 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			

Child's name:			
sought and recorded			
Evidence that the carer's concerns/comments have been sought and recorded			
Evidence that information has been gathered to inform the assessment from the placing social worker and other health professionals providing care (eg child and adolescent mental health services (CAMHS), therapies, hospital services, GP)			
Is the child or young person is registered with a GP in the area?			
The child or young person is registered with a dentist or has access to dental treatment			
Date of most recent dental check or if the subject has refused this intervention			
The child or young person has been seen by an optician Date of most recent eye test or if the subject has			

Child's name:			
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:			

162. Please also see the following guidance:

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

11. Community Diagnostic Centres

163. Note: Community Diagnostic Centre (CDC) activity only relates to activity carried out by approved CDC sites.

164. All activity delivered by approved Community Diagnostic Centres (CDCs) should be paid for using the unit prices published in the CDC tab of NHSPS (Annex DpA).

165. While prices should be used for CDC activity, in some cases there is also separate CDC revenue funding provided to ICBs to cover specific and time-limited start-up and other costs. Where this is the case, this should be transacted through the API fixed element as a non-recurrent adjustment.

166. The approach to CDC provider payment in 2025/26 is therefore as follows:

- The planned amount payable for the trust's CDC services will be the host ICB's full CDC allocation from NHS England for that CDC. This will be reflected in Schedules 3A (Aligned Payment and Incentive Rules) and 3D (Expected Annual Contract Values) of the NHS Standard Contract between the ICB and the trust.
- Under the arrangements set out in Service Conditions 28, 29 and 36 of the Contract, the ICB will make monthly payments on account to the trust, the trust will report monthly to the ICB and national teams on actual activity volumes and weighted values, and there will be a joint process between the ICB and trust of quarterly reconciliation to adjust payment as necessary to reflect actual activity volumes (for the direct cost element only).

167. In that reconciliation process:

- The "Central revenue funding" element of the payment will be treated as a fixed amount, unless there is slippage in the agreed CDC "go live" date, in which case the national CDC program may withhold the relevant proportion from its payments to the ICB and therefore to the Trust.
- The "direct cost" element of the payment will operate on a fully variable basis.

11.1 Alternative payment arrangements for services in designated CDCs in 2025/26

168. The NHSPS rules allow API payment arrangements to be varied locally, by agreement between the commissioner and the trust and subject to NHS England's approval. Where systems wish to operate alternative payments arrangements, this variation process should be followed.

11.2 Information and data requirements

169. As a condition of accepting the CDC allocation, ICBs and CDC providers must also agree to submit activity data to:

- the national programme via NCDS; and
- SUS including using the approved CDC site code to ensure that there is clarity between CDC and non-CDC diagnostic activity.

12. Teledermatology

170. Teledermatology refers to the use of specialist camera equipment (dermatoscope) to take pictures of new or changing skin lesions for patients who have seen their GP and there is a concern about the possibility of skin cancer.

171. There are three typical image-taking scenarios for patients with suspected skin cancer:

- The GP takes the dermatoscope image, which is included with the urgent suspected cancer referral.
- The patient is sent to a Community Diagnostic Centre (CDC) for a dermatoscope image to be taken.
- The patient is referred on an urgent suspected cancer pathway and is sent to a medical photographer or a suitable trained staff in secondary care for the dermatoscope image to be taken.

172. Following the image being taken through any of the routes specified above, a dermatologist reviews these images (without the patient in attendance), and a decision is made on whether to discharge the patient or to bring them in for a first outpatient appointment.

173. For 2025/26, the price for patients with suspected skin cancer should apply as follows:

- Where the dermatoscope image is taken by the GP, but the virtual review of the image is undertaken by a dermatologist, the providers and commissioners should agree an appropriate split to apply to the review element.
- Where the dermatoscope image takes place in a CDC, there is a price for 2025/26 (see Annex DpA) which covers both the dermatoscopy and the reporting.
- Where the dermatoscope image is taken at hospital and virtually reviewed, providers and commissioners should apply the CDC price for Dermoscopy and Report (set out in Annex DpA). This would be part of the variable element. The dermatoscopy and/or reporting of the dermatoscopy should not be treated as an outpatient appointment.

174. For patients on a routine pathway, where the GP sends a regular image to secondary care for advice and guidance, this would follow the routine Advice and Guidance pathway.

Currencies with NHS Payment Scheme guide prices

The currencies in this section have guide prices published in Annex DpA of the NHS Payment Scheme. Guide prices are intended to support local payment arrangements.

13. A&E services

175. The following currencies for A&E services are based on A&E attendances. Guide prices for these currencies are set out in Annex DpA, tab 6.

VB01Z	Emergency Medicine, Any Investigation with Category 5 Treatment
VB02Z	Emergency Medicine, Category 3 Investigation with Category 4 Treatment
VB03Z	Emergency Medicine, Category 3 Investigation with Category 1-3 Treatment
VB04Z	Emergency Medicine, Category 2 Investigation with Category 4 Treatment
VB05Z	Emergency Medicine, Category 2 Investigation with Category 3 Treatment
VB06Z	Emergency Medicine, Category 1 Investigation with Category 3-4 Treatment
VB07Z	Emergency Medicine, Category 2 Investigation with Category 2 Treatment
VB08Z	Emergency Medicine, Category 2 Investigation with Category 1 Treatment
VB09Z	Emergency Medicine, Category 1 Investigation with Category 1-2 Treatment
VB10Z	Emergency Medicine, Dental Care
VB11Z	Emergency Medicine, No Investigation with No Significant Treatment
VB99Z	Emergency Medicine, Patient Dead On Arrival

176. Of the 12 currencies, the ten emergency medicine currencies are separated into complexity levels based on the investigation treatment categories that formed part of the Accident and Emergency Commissioning Data set, which has now been replaced by the Emergency Care Data Set (ECDS). The HRGs do not cover activities within clinical decision unit and observation type wards/units.

177. The HRG assigned to each attendance depends on the dominant investigation/ and a dominant treatment and their respective complexity categories of care.

178. To generate HRGs from the ECDS, data fields need to be mapped back to the investigation codes and treatment codes as previously recorded within the Accident and Emergency Commissioning Data Set, prior to grouping.

179. When a care provider submits the Emergency Care Data Set (ECDS) to SUS, the SUS+ national grouper does the mapping automatically and generates the appropriate HRGs. For grouping the data locally, the mapping of investigation codes and treatment codes can be found in the Enhanced Technical Output Specification (ETOS) for the ECDS. See sheets ‘22.1 INVESTIGATION’ and ‘23.1 TREATMENT’ in the Enhanced Technical Output Specification (ETOS).

180. Same Day Emergency Care (SDEC) activity is recorded in the Emergency Care Data Set (ECDS) as a Type 5 A&E attendance. Prior to April 2023, the majority of SDEC activity was coded as a zero-day length of stay emergency admission.

181. Under the NHSPS rules, all SDEC activity delivered by NHS providers should be funded as part of the API fixed element or an LVA arrangement where applicable, irrespective of how it had previously been coded. No provider should lose income as a result of the recording change.

182. All A&E prices are guide prices and can be used as benchmarks or supporting information for setting API fixed elements, or for local payment arrangements. Due to the changes in SDEC reporting, and the uncertainty of what impact it will have, all NHSPS prices for non-elective services are also guide prices, rather than unit prices.

14. Maternity pathways

183. Under the NHSPS, maternity services delivered by NHS providers should be funded through the API fixed element or, where under the threshold, LVA arrangements. See the section below on ensuring the fixed element reflects the resource requirements of maternity services.

184. This section provides details of the maternity pathway payment (MPP), which was used to pay for maternity services in the National Tariff prior to 2021/22.

185. In the NHSPS, there are two types of prices published for maternity services: HRG-level prices and MPP prices. These prices are published in Annex DpA, along with supporting information on factors, definitions and technical information. However, prices are not expected to be used for payments. The prices are published as guide prices, meaning maternity services delivered by non-NHS providers are subject to local payment arrangements.

186. In the circumstance where activity-based payments for maternity services is locally agreed, this should be based on HRG-level prices. We have continued to publish MPP prices and provide details of the pathway. This provides information about the pathway payments which were in place prior 2021/22. As such, the following information should be used in the context of reviewing previous payment arrangements which may be linked to MPP methodology.

187. Under the NHSPS rules, provider-to-provider payments for maternity services should not be required. Payment approaches should be reflective of the anticipated cost of delivering system plans and should therefore not require intra-provider cross-charging. If you have any questions, please contact england.pricingenquiries@nhs.net.

188. For 2025/26, maternity prices have been uplifted to return to the pre-pandemic cost base (see Annex DpD). These guide prices should be used to support setting of API fixed payments.

Ensuring the fixed element reflects the resource requirements of maternity services

189. For 2025/26, almost all maternity services will be funded through API fixed elements, which is designed to meet the costs of delivering the service plan. Fixed elements can be used to provide certainty, and support planning and forecasting.

190. Fixed elements relating to maternity services should be aligned to Local Maternity System (LMS) plans by supporting the delivery of system objectives, including the training of staff to meet these needs.

191. Any changes to service models for maternity services between the source data used and what is planned for 2025/26 should be reflected in the fixed element. This could be changes in the expected level of births, or changes to the configuration of service delivery between providers across a system.

192. The specific CNST sub-chapter value relating to maternity services set out in Annex DpD must be factored in to fixed elements.

193. The fixed element should also give regard to the Immediate and Essential Actions to Improve Care and Safety in Maternity Services within the Ockenden Report, which includes resourcing Maternal Medicine Networks and Birth-rate Plus.

194. Where there is significant uncertainty around expected levels of activity for maternity services and therefore the correct value for payments, a local risk share agreements can be agreed, for example using the model SCFMA.

14.1 What is the maternity pathway?

195. Pathway prices are a guide prices for a bundle of services that may be provided by several providers for an entire episode or whole pathway of care for a patient.

196. The maternity pathway payment 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. 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.

197. 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.

198. Table 6 sets out what is included and excluded from the three stages of the maternity pathway price values.

Table 6: The maternity pathway payment

Area	Included	Excluded
Admitted patient care	All activity against NZ* HRGs (ie any HRG beginning with the code NZ), regardless of TFC.	All activity against non-NZ* HRGs (regardless of TFC)

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
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

Area	Included	Excluded
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
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 unit prices

14.2 Structure of the maternity pathway

199. The maternity pathway payment splits maternity care into three phases: antenatal, delivery/birth and postnatal. This section sets out guidance and business rules for each.

The antenatal pathway

200. The antenatal pathway 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. 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.

201. 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).

202. The characteristics (factors) that determine casemix level and payment are set out below. Details of the technical information relating to the factors are available in Annex DpA.

Factor	Antenatal pathway	Definition, examples
Current factors		
Expecting twins or more	Intensive	Expecting two or more babies
Alcohol use	Intermediate	Defined as 14 units or more per week
BMI greater than 35 and less than or equal to 49	Intermediate	
BMI less than 18	Intermediate	
Complex social factors	Intermediate	NICE clinical guideline 110 defines the extra care required for women with complex social factors. Clinicians should decide whether this extra care will be required for the pregnant woman. For payment purposes, Learning Disability and Safeguarding have been added to the NICE definition, which includes: • Domestic abuse: an incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. It can also include forced marriage, female genital mutilation and 'honour violence'. • Recent migrants: women who moved to the UK within the previous 12 months. Clinicians should determine whether all recent migrants are at risk due to social complexity • Substance misuse (alcohol and/or drugs): regular use of recreational drugs, misuse of over-the-counter medications, misuse of prescription medications, misuse of alcohol or misuse of volatile substances (such as solvents or inhalants) to an extent whereby physical dependence or harm is a risk to the woman and/or her unborn baby.
Sensory or physical disabilities	Intermediate	Sensory impairment (blind, serious visual impairment uncorrected by glasses, deafness or serious hearing impairment). Physical or mobility issues such as cerebral palsy, difficulty using arms or using a wheelchair or routinely using walking aid such as crutches or walking stick

Factor	Antenatal pathway	Definition, examples
Substance use	Intermediate	Substance misuse (alcohol and/or drugs): regular use of recreational drugs, misuse of over-the-counter medications, misuse of prescription medications, misuse of alcohol or misuse of volatile substances (such as solvents or inhalants) to an extent whereby physical dependence or harm is a risk to the woman and/or her unborn baby. Examples of non-medicinal drugs or other unauthorised substances are; cocaine, crack, heroin, Marijuana, Morphine, Solvents (e.g. glue, aerosol)
Medical factors		
Autoimmune disease	Intensive	Pre pregnancy diagnosis or diagnosed in current pregnancy- Myasthenia Gravis Systemic Lupus Erythematosus, rheumatoid arthritis, systemic sclerosis, psoriatic arthropathy, autoimmune hepatitis, autoimmune hypothyroidism, ITP
BMI greater than or equal to 50	Intensive	
Cancer	Intensive	Current cancer or in past 3 years prior to conception
Cardiac disease	Intensive	Severe enough to be currently under a secondary care provider
Central Nervous System disorder	Intensive	Myotonic dystrophy Multiple sclerosis Spinal problems (spine bifida/occulta) Generalised neuropathies (e.g. Charcot Marie Tooth) Severe migraine Stroke Previous history of subarachnoid haemorrhage
Diabetes and other endocrine disorders	Intensive	Diabetes, Addison's disease, hyperthyroidism, Cushing's syndrome
Haematological disorder: clotting disorder or other thrombophilia	Intensive	Antiphospholipid syndrome, Protein C deficiency, Protein S deficiency, Antithrombin deficiency, factor V Leiden homozygosity, prothrombin gene variant homozygosity, compound heterozygotes von Willebrands disease, haemophilia, thrombocytopenia;
Haemoglobinopathy	Intensive	Sickle cell disease, thalassaemia,
Human Immunodeficiency Virus (HIV)	Intensive	HIV attacks cells that fight infection, resulting in greater vulnerability to other infections and diseases. Untreated HIV can result in Acquired Immunodeficiency Syndrome (AIDS). For payment purposes, a diagnosis prior to the current pregnancy, or one which occurs in the current pregnancy should attract the higher payment level.
Maternal cystic fibrosis	Intensive	Maternal history of Cystic fibrosis
Portal Hypertension	Intensive	Maternal portal hypertension due to high risk pregnancy requiring complex joint care
Previous fetal congenital anomaly that required specialist fetal medicine	Intensive	Previous fetal congenital anomaly that required referral to a specialist fetal medicine centre (from 2019, a hub or spoke specialist fetal medicine centre)
Previous Organ Transplant	Intensive	Maternal history of transplants in any of: heart, lung, kidney, liver or bone marrow
Renal disease	Intensive	Chronic renal disease or failure, glomerulonephritis,glomerulosclerosis, Henoch-Schonlein Purpura, Haemolytic uremic syndrome, IgA Nephropathy, Lupus Nephritis,Dysplasia, Nephrotic syndrome, Polycystic kidney disease

Factor	Antenatal pathway	Definition, examples
Rhesus isoimmunisation	Intensive	A blood incompatibility disorder where the mother's blood type is not compatible with the fetus. This incompatibility results in antibodies from the mother's blood destroying the baby's red blood cells when they come into contact during pregnancy and after birth. For payment purposes, a previous history of maternal isoimmunisation in a previous pregnancy, or diagnosed in the current pregnancy should attract this payment level.
Thromboembolic disorder	Intensive	Previous venous thrombosis, previous arterial thrombosis, previous pulmonary embolism
Epilepsy requiring anti-convulsant therapy	Intermediate	
Hepatis B or C	Intermediate	Maternal history of Hepatitis B or C diagnosed pre-pregnancy, or within the current pregnancy
Hypertension	Intermediate	Pre-existing diagnosis of hypertension requiring medication
Inherited Disorder	Intermediate	Inherited disorder requiring active follow up in secondary care.
Mental health	Intermediate	Under care of secondary mental health services. Previous Puerperal psychosis, previous suicide attempt, previous psychiatric inpatient episode or detention under the Mental Health Act.
Pregnancy Associated Plasma Protein A (PAPP-A) ≤0.415MoM	Intermediate	PAPP-A result from 1st trimester combined Downs, Edwards and Patau syndrome screening test with a result of ≤0.415MoM in the current pregnancy.
Previous uterine surgery	Intermediate	Previous Caesarean section, myomectomy, septectomy, endometrial ablation
Respiratory disease	Intermediate	Moderate or severe asthma - under secondary care or required a hospital admission in last year, or any ITU admission for asthma in the past. Sarcoidosis, pulmonary fibrosis, chronic obstructive pulmonary disease, tuberculosis
Gastroenterological disorder	Intermediate	For example: Crohns, Ulcerative colitis, malabsorption syndromes, gastric ulcer. Achalasia. Other hepatitis. To meet the payment threshold, the woman's condition must routinely require care under secondary or consultant care.
Previous obstetric history		
Previous fetal congenital anomaly that required specialist fetal medicine	Intensive	Pregnancy that required attendance at a specialist fetal medicine service and would code to the HRGs NZ71Z, NZ72Z and NZ21Z. From 2019, this will include a specialist hub or spoke fetal medicine service
Abnormally invasive placenta	Intermediate	History of placenta accreta requiring referral to specialist centre
Early pre-term birth	Intermediate	History of a Birth ≤34 weeks 0 days
Eclampsia	Intermediate	'Eclampsia' is defined as: • Occurrence of one or more convulsions superimposed on pre-eclampsia.
Fetal loss	Intermediate	In utero death-fetal loss between 12 weeks and 0 days and 23 weeks and 6 days
HELLP	Intermediate	'HELLP' is defined as: • A combined liver and blood clotting disorder which is a complication of pre-eclampsia.
High birth weight baby	Intermediate	Birth weight of a previous baby of ≥4.5kgs

Factor	Antenatal pathway	Definition, examples
Intrauterine fetal growth restriction	Intermediate	Growth restriction suggests a pathological restriction of the genetic growth potential. Intrauterine fetal growth restriction will present with evidence of fetal compromise (e.g. abnormal Doppler studies, reduced liquor volume) and potentially a Low birth weight (LBW). A LBW infant is one whose birth weight < 2500 g. Small–for–gestational age (SGA) refers to an infant born with a birth weight less than the 10th centile
Low birth weight baby	Intermediate	birth weight of a previous baby of ≤2.5kgs
Miscarriage	Intermediate	History of 3 or more *consecutive* miscarriages
Neonatal death	Intermediate	History of a neonatal death following a live birth during the first 28 days of life.
Puerperal psychosis	Intermediate	Puerperal psychosis' is a group of illnesses and defined as: • Serious mental illness, developing in a woman shortly after birth. There are 3 main illnesses that happen during this time: o Mania o Depression o Schizophrenia
Severe Pre-eclampsia requiring pre-term birth	Intermediate	'Severe pre-eclampsia' is defined as • Severe hypertension (a diastolic blood pressure ≥ 110 mmHg on two occasions or systolic blood pressure ≥ 170 mmHg on two occasions) and significant proteinuria (at least 1 g/litre).
Stillbirth	Intermediate	After 24 weeks and 0 days, a still birth occurs if the baby makes no respiratory effort and is dead at birth
Other		
Age	Intermediate	Maternal age at booking <20 years

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

- 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.

204. 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

205. 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.

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

The birth episode pathway

207. 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.

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

209. 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.

210. 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 the efficiency and cost uplift factors.

211. 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

212. 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.

213. 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.

214. Details of the postnatal risk factors are set out below.

Factor	Postnatal pathway	Definition, examples
Current factors		
BMI greater than or equal to 50	Intensive	
Alcohol use	Intermediate	Defined as 14 units or more per week
BMI greater than 35 and less than or equal to 49	Intermediate	
Complex social factors	Intermediate	NICE clinical guideline 110 defines the extra care required for women with complex social factors. Clinicians should decide whether this extra care will be required for the pregnant woman. For payment purposes, Learning Disability and Safeguarding have been added to the NICE definition, which includes: • Domestic abuse: an incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. It can also include forced marriage, female genital mutilation and 'honour violence'. • Recent migrants: women who moved to the UK within the previous 12 months. Clinicians should determine whether all recent migrants are at risk due to social complexity • Substance misuse (alcohol and/or drugs): regular use of recreational drugs, misuse of over-the-counter medications, misuse of prescription medications, misuse of alcohol or misuse of volatile substances (such as solvents or inhalants) to an extent whereby physical dependence or harm is a risk to the woman and/or her unborn baby
Substance use	Intermediate	Examples of non-medicinal drugs or other unauthorised substances are; Cocaine, Crack, Heroin, Marijuana, Morphine, Solvents (e.g.glue, aerosol)
Medical factors		
HIV	Intensive	Woman diagnosed with HIV either prior to or within the current pregnancy
Renal disease	Intensive	Chronic renal failure, glomerulonephritis, glomerulosclerosis, Henoch-Schonlein Purpura, Haemolytic uremic syndrome, IgA Nephropathy, Lupus Nephritis, Dysplasia, Nephrotic syndrome, Polycystic kidney disease
Acute Fatty Liver of Pregnancy (AFLP)	Intermediate	Previous history or current pregnancy history of AFLP- usually presents in the third trimester, although it may occur any time in the second half of pregnancy, although typically between 35-36 weeks pregnant. Presentation in the puerperium is also common.
Cardiac disease	Intermediate	Maternal history which is severe enough to be currently under a secondary care provider during the current pregnancy and /or postnatal period

Factor	Postnatal pathway	Definition, examples
Central Nervous System-Neurological disorders	Intermediate	Myotonic dystrophy Multiple sclerosis Spinal problems (spine bifida/occulta) Generalised neuropathies (e.g. Charcot Marie Tooth) Severe migraine Stroke Previous history of subarachnoid haemorrhage
Diabetes and other endocrine disorders	Intermediate	Maternal Diabetes, Addison's disease, hyperthyroidism, Cushing's syndrome
Inherited disorder	Intermediate	Maternal inherited disorder requiring active follow up in secondary care.
Mental health	Intermediate	Under care of secondary mental health services. Previous or current Puerperal psychosis, previous suicide attempt, previous psychiatric inpatient episode or detention under the Mental Health Act.
OASIS/Postnatal bladder dysfunction	Intermediate	Occurred in either a previous or current pregnancy: Obstetric Anal Sphincter Injuries (OASIS) are defined as occurring in: • 3rd degree tears which involve the anal sphincter complex; or • 4th degree tears with injury to the perineum involving the internal and external anal sphincter complex and anorectal mucosa.
Post ITU admission	Intermediate	Maternal history of an ITU admission during the antenatal, birth or postnatal phase of the current pregnancy
Puerperal psychosis (Level 2/3 critical care)		Puerperal psychosis' is a group of illnesses and defined as: • Serious mental illness, developing in a woman shortly after birth. There are 3 main illnesses that happen during this time: o Mania o Depression o Schizophrenia Intermediate payment level is appropriate when a woman has a history of one or more of these conditions or develops one or more in her current pregnancy.
During this pregnancy		
Fetal anomaly	Intensive	Fetal anomaly requiring specialist fetal medicine involvement occurring within the current pregnancy
Cystic fibrosis	Intensive	Maternal history of cystic fibrosis
Pulmonary hypertension	Intensive	Maternal history of pulmonary hypertension, defined as systolic pressure in the pulmonary artery exceeding 30 mm Hg. It is most commonly seen in pre-existing pulmonary or cardiac disease but may occur (although rarely) as a primary condition when it is produced by fibrosis and thickening of the vessel intima.
Peripartum cardiomyopathy	Intensive	Peripartum cardiomyopathy is a rare form of heart failure, occurring from 36 weeks gestation, up to 5 months postnatally. For payment purposes, a maternal history of peripartum cardiomyopathy in a previous or the current pregnancy should trigger the intensive payment, due to the risk of relapse and the monitoring required in subsequent pregnancies.
Organ transplants	Intensive	Maternal history of transplants in any of: heart, lung, kidney, liver or bone marrow.
Multiple pregnancy	Intermediate	Birth of two or more babies.

Factor	Postnatal pathway	Definition, examples
Gestational hypertension	Intermediate	'Gestational hypertension' is defined as: • New hypertension presenting after 20 weeks without significant proteinuria . Hypertension is defined as: • Mild hypertension diastolic blood pressure 90–99 mmHg, systolic blood pressure 140–149 mmHg. • Moderate hypertension diastolic blood pressure 100–109 mmHg, systolic blood pressure 150–159 mmHg. • Severe hypertension diastolic blood pressure 110 mmHg or greater, systolic blood pressure 160 mmHg or greater. 'Proteinuria' is defined as: • if the urinary protein: creatinine ratio is greater than 30 mg/mmol or a validated 24-hour urine collection result shows greater than 300 mg protein.
Gestational diabetes	Intermediate	'Gestational diabetes' is defined as:• Carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy and with a return to normal after birth. It is diagnosed when the woman has either: a fasting plasma glucose level of 5.6 mmol/litre or above or a 2-hour plasma glucose level of 7.8 mmol/litre or above.
Neonatal death	Intermediate	Either a history of a neonatal death following a previous pregnancy or a neonatal death in the current pregnancy. A neonatal death is classified as occurring up to 28 days of life.
Stillbirth or termination of pregnancy after 24 weeks 0 days of gestation	Intermediate	Either a history in previous pregnancy or the current pregnancy. After 24 weeks and 0 days gestation, the baby made no respiratory effort and is declared dead at birth.
Eclampsia	Intermediate	'Eclampsia' is defined as: • Occurrence of one or more convulsions superimposed on pre-eclampsia .
HELLP	Intermediate	'HELLP' is defined as: • A combined liver and blood clotting disorder which is a complication of pre-eclampsia . 'Pre-eclampsia' is defined as: • Pregnancy-induced hypertension is haemolysis, elevated liver enzymes and low platelet count.
Deep vein thrombosis Pulmonary embolism	Intermediate	'Venous thromboembolism' is defined as: The blocking of a blood vessel by a blood clot formed at or dislodged from its site of origin. It includes both Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE). Deep vein thrombosis (DVT)' is defined as: Venous thrombosis that occurs in the "deep veins" in the legs, thighs, or pelvis. 'Pulmonary embolism (PE)' is defined as: A blood clot that breaks off from the deep veins and travels round the circulation to block the pulmonary arteries (arteries in the lung).
Other		
Age	Intermediate	Maternal age at booking ≤ 20 years old

215. 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.

216. All postnatal care, as defined in NICE clinical guidance on postnatal care which women and their babies should receive in the first 8 weeks after the birth, is included in the pathway, 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.

217. 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.

218. 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.

219. 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.

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

Information flows for the antenatal and postnatal pathways

221. The Maternity Services Data Set (MSDS) has collected data since April 2015.

15. Critical care – adult, paediatric and neonatal

222. 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.

223. The HRG currencies for adult, paediatric and neonatal critical care services are derived from a subset of the critical care minimum datasets.

224. Payment for all critical services is included in the API fixed element.

15.1 Adult critical care

225. 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.

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

227. The HRGs for adult critical care (subchapter XC) are unbundled from the rest of the patient spell and 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 7: 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 organ supported
XC07Z	Adult critical care – 0 organs supported

228. NHSPS prices have not been set for these services and payment for these HRGs should form part of API agreements.

15.2 Paediatric critical care

229. 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

230. 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

231. 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.

232. 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.

233. 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).

234. 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

235. The HRGs for paediatric critical care services (subchapter XB, see Table 8 below) are determined daily by the level of critical care resource usage (e.g., medical and nursing staff costs, equipment and drug costs associated with the care required for a patient).

236. The structure of the HRGs currency design with this subchapter are split into eight levels of complexity. There are five HRGs specific to paediatric intensive care activity, which would be undertaken in a paediatric intensive care unit (PICU). Three HRGs are specific to paediatric high dependency care activity. The HRGs are unbundled and generated in addition to the core HRGs for the associated admitted patient care episode or spell.

237. 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.

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

Table 8: 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

239. XB08Z (transportation) is derived from the APC data set as the Paediatric Critical Care data set does not incorporate data items that can be used to identified transportation or retrieval.

240. 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.

241. 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.

242. Data should be “grouped” using the correct grouping logic that processes the activity to the correct HRG. For example, the HRG4+ 2025/26 Local Payment Grouper will be

used for the NHSPS in 2025/26, whereas the HRG4+ 2018/19 Reference Cost Grouper was used for the 2018/19 national cost collection.

243. 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:

- 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.

244. 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 9).
- HRG XB02Z-XB05Z can only occur within one of the 20 designated PICU (Level 3) providers across England (see Table 10).
- 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.

245. 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 9: 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
RR8	Leeds Teaching Hospitals NHS Trust
RHM	Southampton University Hospitals NHS Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Organisation Code	Organisation Name
RA7	University Hospitals Bristol NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust

Table 10: 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
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

246. 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.

247. 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.

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

Table 11: 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 guide prices

249. These services do not have unit prices. However, we have determined and published guide prices for paediatric critical care, which are published in Annex DpA.

250. These guide prices have been set using data from the 2018/19 national cost collection, applying the NHSPS price calculation method and, after determining national average costs, applying the relative weights from Table 11 to reweight the costs.

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

252. 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 guide price for this HRG.

15.3 Neonatal critical care

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

Currencies, data sets and cost weightings

254. 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.

Table 12: 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

255. 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).

256. The NCCMDS was approved as a standard for use by the Standardisation Committee for Care Information (SCCI).

257. Data from the NCCMDS version 2.0 (2016 release) has been used to inform the reporting of PLICS costs against the unbundled HRGs XA01Z to XA05Z.

258. 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:

- 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.

259. 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.

260. 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.

261. These HRG weightings are based on the BAPM Service Standards for Hospitals providing Neonatal Care 2010. They are provided as a guide (see Table 13) and will be subject to refinement over time.

Table 13: 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

HRG	Description	Relative Weight
XA05Z	Neonatal Critical Care, Normal Care	0.6

Types of neonatal unit and levels of care

262. There are three types of neonatal unit, which deliver three levels of care. 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. These units and their levels of care are listed in Table 14.

Table 14: 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

263. 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-located neonatal surgical service (see Implementing the Recommendations of the Neonatal Critical Care Transformation Review, page 6). 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.

264. In addition to the above expectations of relative weighting of cost according to HRG (see paragraph 260 above and Table 13), 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 guide prices

265. These services do not have unit prices. However, we have determined and published guide prices for neonatal critical care services to support the development of local prices. See Annex DpA.

266. In setting the 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 260 above and Table 13.

267. The guide prices will be subject to further testing and review. Commissioners and providers should work together to review their application.

268. XA06Z relates to neonatal critical care transport and its guide 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 guide price for this HRG.

269. As the Neonatal Level of Care (corresponding to the Type of Neonatal Critical Care Unit in Table 14), 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 guide prices of HRGs XA01Z to XA05Z.

270. 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 england.pricingenquiries@nhs.net if you have any questions.

16. Renal dialysis for acute kidney injury

271. There are four HRGs (LE01A, LE01B, LE02A and LE02B) for dialysis for acute kidney injury. These cover renal dialysis activity specifically for the treatment of acute kidney injury as part of an admitted care episode, for patients of all ages. 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 in an inpatient and day case setting. One HRG will be generated for each session of dialysis.

272. Unit prices have not been set for these services, but 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). The currencies LE01B and LE02B are for the respective dialysis for patients 18 years and under – see Annex DpA for details.

17. Renal transplant

273. 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.

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

275. 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.

276. We have worked with NHS England Specialised Commissioning to move towards bringing the renal transplant procedure into the scope of the API elective variable element. To support this, in 2024/25 we introduced NHSPS guide prices for the kidney transplant episode and live donation of kidney episode for both adult and paediatric services. Providers should ensure activity flows in SUS, correctly grouping to the renal transplant HRG codes i.e. do not apply the "=" exclusion. Details of the paediatric currency have been added to this section. Guide prices covering outpatient activity in the adult kidney transplantation patient pathway are published in Annex DpA to support the development of local prices.

17.1 What is the renal transplant currency?

277. The currency uses existing 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. The currency also covers the paediatric transplant episode.

278. 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.

17.2 What does the pathway cover?

279. There are already HRGs relating to this activity: LA01A, LA01B, LA02A, LA02B, LA03A, LA03B, 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 15 and described in more detail in sections 15.3 and 15.4.

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

- LA12A – Kidney pre-transplantation work-up of recipient, 19 years and over
- LA12A – Maintenance on the transplant list
- Kidney transplant episode
  - LA01A: Kidney transplant, 19 years and over, from cadaver non-heart beating donor
  - LA01B: Kidney transplant, 18 years and under, from cadaver non-heart beating donor
  - LA02A: Kidney transplant, 19 years and over, from cadaver heart beating donor
  - LA02B: Kidney transplant, 18 years and under, from cadaver heart beating donor
  - LA03A: Kidney transplant, 19 years and over, from live donor
  - LA03B: Kidney transplant, 18 years and under, from live donor
  - LA13A: Examination for post-transplantation of kidney of recipient, 19 years and over.

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

- LA10Z: Live kidney 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.

282. 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.

17.3 What is included in the price?

283. The guide prices cover all outpatient and inpatient activity in the adult kidney transplant patient pathway, all inpatient activity in the paediatric kidney transplant patient pathway and the live donor pathway. There are several phases associated with the pathway:

Transplant assessment

284. 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.

285. The kidney transplant pathway 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

286. 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.

287. 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

288. 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

289. Activity is captured by one of six HRG codes (LA01A, LA01B, LA02A, LA02B, LA03A and LA03B), depending on whether the donor is non-heart beating (DCD), heart-beating (DBD) or live donor (LD) and whether the recipient is an adult or child. LA01A/B and LA02A/B will always be captured as a non-elective inpatient activity and LA03A/B as elective inpatient activity.

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

Live donor nephrectomy

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

Post-transplant follow-up

292. 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.

293. 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

294. 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.

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

17.4 What is excluded from the price?

296. The following are explicitly not included in the guide price:

- The consultation at which all modalities of renal replacement therapy are considered.
- Kidney transplants with simultaneous pancreas transplants, or other multi-organ transplants incorporating a kidney transplant.

- 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.
- 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.

297. 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.

298. 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.

299. 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.

17.5 Drugs

300. 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.

301. 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/

302. 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 15: 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, 19 years and over	• 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, 19 years and over, from cadaver non-heart beating (DCD) donorr	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	
LA01B	Kidney transplant, 18 years and under, from cadaver non-heart beating donor			
LA02A	Kidney transplant, 19 years and over, from	Inpatient transplant episode		

HRG	Code descriptor	Activity included in currency	Activity excluded from currency	Comments
	cadaver heart beating donor (DBD)		• 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	
LA02B	Kidney transplant, 18 years and under, from cadaver heart beating donor			
LA03A	Kidney transplant, 19 years and over, from live donor	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	
LA03B	Kidney transplant, 18 years and under, from live donor			
LA13A (OP procedure code M174)	Examination for post-transplantation of kidney of recipient, 19 years and over	• 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	Telephone clinics included if OP procedure code M174 used

HRG	Code descriptor	Activity included in currency	Activity excluded from currency	Comments
			• Any specialist opinion • Any emergency readmission • Removal of ureteric stent or PD catheter unless done on initial admission	
Live donor pathway				
LA10Z (OP procedure code M171)	Live kidney 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

18. Adult cardiothoracic transplantation

303. Heart transplantation (HTx) provides the best quality of life and survival for carefully selected patients with advanced heart failure. Lung transplantation is an established treatment for irreversible lung failure. It offers carefully selected individuals improvement in survival and quality of life.

304. The UK has poor rates of both lung and heart transplantation, compared to other countries, with many patients dying or being removed from the list within a year of being listed for a transplant; there therefore remains a substantial unmet need for transplant.

305. NHS England also commissions Long-Term Ventricular Assist Device (LVAD) implantation as a bridge to organ transplantation and as a bridge to candidacy for heart transplantation. Implanting an LVAD can be lifesaving. This section introduces a change to the way adult cardiothoracic transplantation is reimbursed. The payment reform (delayed because of Covid19) is a response to commitments to reach the targets set out in national strategy including Organ Donation and Transplantation 2030: Meeting the Need and also to support the introduction of the Organ Donation (Deemed Consent) Act 2019.

306. The previous payment system for this service had not supported ambitions to increase heart and lung transplantation as it inadequately reimbursed expansion of transplantation activity: low marginal rates were paid per transplant while very high marginal rates were paid per LVAD procedure. The currency and marginal payment rate is designed appropriately to reward efforts to enable transplantation both of lungs and of hearts.

307. In the context of broader developments in the payment system, the fixed payment should be reviewed and associated with variation in transplantation activity relative to a baseline level of funded activity from each provider. That baseline should be that which is funded by the overall funding envelope established for that provider, ie the funding envelope for all services covered by their NHS England contract. It is for providers to ensure that their transplant service is appropriately funded within the provider's overall revenue. The intention is to move towards cardiothoracic activity being funded with the variable element of the API over time. Providers should ensure activity flows in SUS, correctly grouping to the cardiothoracic transplant HRG codes i.e. do not apply the "=" exclusion.

308. The new payment approach introduces a variable payment element that reflects estimated full costs of additional transplantations, including an average allowance for

LT VAD procedures. There are no separate payments for LT VAD procedures. Device costs for both short-term and long-term devices continue to be funded separately via pass-through arrangements. The reform relates to the adult cardiothoracic transplantation programme.

18.1 What is the cardiothoracic transplant currency?

309. The currencies use existing HRGs and covers all care directly relating to the preparation and provision of cardiothoracic transplant services.

310. Activity will be measured using the following currencies only:

- Heart transplantations (HRG: ED04Z/ED05Z)
- Lung or Heart & Lung transplantations (HRG: DZ01Z/ ED01Z)
- Post-transplant patients following either type of transplantation cared for the whole year or a part thereof
- Short Term Ventricular Assist Device (ST VAD) implant procedures (HRG: ED06Z/ED07Z)
- Long Term VAD (LT VAD) implant procedures (zero priced) (HRG: ED08Z/ED09Z).

18.2 What services are guide prices required for?

311. Guide prices for cardiothoracic transplant services are published in Annex DpA to support the development of local prices.

312. For these services, the provider and commissioner must apply the payment principles specified in Section 3.1 of the NHSPS and have regard to the cost uplift and efficiency factors. The provider and commissioner must agree the fixed API value, having regard to NHS England Specialised Commissioning guidance and information on these services. Providers and commissioners can use the guide prices in Annex DpA to help in the negotiation of setting the contract value for these services.

313. We are recommending in this way a move towards setting standard price per transplant (net of MFF) at a level consistent with historic levels of funding attributed to this service across the country, allowing for modest growth in transplantation rates. The term ‘suggested price’ is used below to mean a locally implemented price that has been determined at a national level as a guide, subject to MFF.

314. The cardiothoracic transplant pricing model consists of the following:

- A suggested price for heart, lung or heart-lung transplants
- A suggested price for post-transplant Year of Care payments

- A suggested price for Short Term VAD implant procedures
- A zero-price for Long Term VAD implant procedures (funding is bundled into the transplant price)
  - NB: Both ST and LT device costs are excluded from the payment reform. Devices will continue to be funded on a pass-through basis.

315. High cost drugs and high cost devices are exclude from the scope of this guide price, in line with the excluded item rules (see NHSPS, Section 3.4).

316. Ventricular Assist Devices (both long- and short-term) have been added to the list included in the Memorandum of Understanding for the High Cost Tariff Excluded Devices (HCTED) programme. National procurement of devices is expected to be implemented in due course.

18.3 What is included and excluded in the guide price?

317. We have worked with clinical and operational colleagues across the country to construct a payment approach that shifts the funding focus to incentivise transplantation. Included in the transplant prices to be paid for variation in activity from baseline is an appropriate level of funding for LVAD implantation procedures (calculated at a national median rate), patient assessment and immediate post-operative care. The new currency structure sets LVAD procedure prices to zero, and bundles the funding for these procedures into the transplantation price. (The reimbursement of the devices themselves will be unchanged.) The funding for the LVAD programme has been bundled across the cardiothoracic transplant service to ensure equity across prices for heart, lung and heart-lung transplant.

318. Similarly, the costs that were previously included in the block and variable element of the payment for lung and heart and lung transplants are bundled into the price by which payment is raised (or lowered) for each lung transplant that exceeds (or falls short of) the number agreed as baseline activity. The aim is to reward success in sustaining and increasing transplantation rates. This will equitably fund providers to support increasing numbers of transplants.

319. Payment variation from baseline payment will be made on the following basis:

- Heart transplantations (complex or standard) (ED04Z/ED05Z); Lung or Heart and Lung transplantations (DZ01Z/ED01Z):
  - Price per transplantation; price includes patient assessment, immediate transplant pre-operative care, post-transplant critical care and remuneration for the LT VAD service (excluding the cost of the devices).

- Post-transplant patients following either type of transplantation cared for the whole year or a part thereof:
  - Year of care payment
- ST VAD implant procedures (ED06Z/ED07Z):
  - Price per SVAD implantation procedure
  - Price does not include the cost of the device, which for both ST VAD and LTVAD will continue to be remunerated on a pass-through basis (subject to HCTED implementation).

19. Bone marrow and peripheral blood stem cell transplant (haematopoietic stem cell transplantation)

320. We are working with NHS England Specialised Commissioning to establish the feasibility of bringing bone marrow and peripheral blood stem cell transplant (haematopoietic stem cell transplantation – HSCT) procedures into the scope of the API elective variable element in future years. To support this, providers should ensure activity flows in SUS, correctly grouping to the HSCT HRG codes i.e. do not apply the "=" exclusion.

19.1 The currency model

321. The HSCT currencies cover procedures and diagnosis for patients of all ages. They include activity undertaken in inpatient, day case and non-admitted care settings.

322. HSCT is not a highly specialised service but is a high-cost surgical service delivered in a limited number of specialist centres. Activity is expected to increase significantly over the next few years.

323. These HSCT service currencies have procedure-driven HRG roots specific to peripheral blood stem cell and bone marrow transplantation, in addition to HRGs specific to blood transfusion, diagnostic extraction and harvest of blood or marrow.

324. The bone marrow and peripheral blood stem cell transplant HRGs are differentiated by donor type, as per the specific OPCS-4 codes, with subsidiary OPCS-4 codes identifying where a related or volunteer-unrelated donor are recorded.

325. The following 19 HRGs are mandated and activity should be submitted via SUS (where it is not already submitted). The currencies use the existing HRG structure and cover all care directly relating to the preparation and provision of HSCT services.

Table 16: HRG currencies for HSCT services

HRG code	HRG name
SA19A	Bone Marrow Transplant, Autograft, 19 years and over
SA19B	Bone Marrow Transplant, Autograft, 18 years and under
SA20A	Bone Marrow Transplant, Allogeneic Graft (Sibling), 19 years and over
SA20B	Bone Marrow Transplant, Allogeneic Graft (Sibling), 18 years and under
SA21A	Bone Marrow Transplant, Allogeneic Graft (Volunteer Unrelated Donor), 19 years and over

HRG code	HRG name
SA21B	Bone Marrow Transplant, Allogeneic Graft (Volunteer Unrelated Donor), 18 years and under
SA22A	Bone Marrow Transplant, Allogeneic Graft (Cord Blood), 19 years and over
SA22B	Bone Marrow Transplant, Allogeneic Graft (Cord Blood), 18 years and under
SA23A	Bone Marrow Transplant, Allogeneic Graft (Haplo-Identical), 19 years and over
SA23B	Bone Marrow Transplant, Allogeneic Graft (Haplo-Identical), 18 years and under
SA26A	Peripheral Blood Stem Cell Transplant, Autologous, 19 years and over
SA26B	Peripheral Blood Stem Cell Transplant, Autologous, 18 years and under
SA27A	Peripheral Blood Stem Cell Transplant, Syngeneic, 19 years and over
SA27B	Peripheral Blood Stem Cell Transplant, Syngeneic, 18 years and under
SA38A	Peripheral Blood Stem Cell Transplant, Allogeneic (Sibling), 19 years and over
SA38B	Peripheral Blood Stem Cell Transplant, Allogeneic (Sibling), 18 years and under
SA39A	Peripheral Blood Stem Cell Transplant, Allogeneic (Volunteer Unrelated Donor), 19 years and over
SA39B	Peripheral Blood Stem Cell Transplant, Allogeneic (Volunteer Unrelated Donor), 18 years and under
SA40Z	Peripheral Blood Stem Cell Transplant, Allogeneic (Donor Type Not Specified)

19.2 Guide prices

326. Guide prices for HSCT services are published in Annex DpA to support the development of local prices and ICB delegation from 2025/26 onwards.

327. High cost drugs and high cost devices are excluded from the scope of the guide prices, in line with the excluded item rules (see NHSPS, Section 3.4).

328. In addition, stem cell components/purchase are excluded from the scope of the guide prices, in line with the excluded item rules. These costs remain within the fixed element

of the API for 2025/26, but will be separately monitored in preparation for potential removal in future years.

329. Note that HRGs SA18Z (Bone Marrow Harvest) and SA33Z (Diagnostic Bone Marrow Extraction) have published unit/guide prices.

20. Specialist rehabilitation

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

331. 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.

332. Guide prices are published in Annex DpA.

20.1 The currency model

333. 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. The same definitions are used to inform the NHS England service specification for specialised rehabilitation for patients with highly complex needs.

334. 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).

335. 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.

336. 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).

337. 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.

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

339. More detailed guidance on implementation and use of the WBD currency model has been prepared through the Clinical Reference Group for Specialist Rehabilitation – see resources available from Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation.

20.2 Guide prices

340. Following work with commissioners and clinicians, through the National Casemix Office Expert Working Groups, UKROC, and the then NHS England Specialised Commissioning clinical reference groups (CRGs) we set non-mandatory prices for the 2019/20 National Tariff, based on UKROC costing and activity data. In the NHSPS, these prices are published as guide prices (see Annex DpA for details).

341. 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 Specialised Commissioning. Submission to the dataset is a commissioning requirement.

21. Diabetic Eye Screening

342. Historically, diabetic eye screening (DES) was legislated for under the Secretary of State's public health functions (also known as Section 7A programmes). This is a separate legal framework to the National Health Service Act 2006 which has dictated the scope of the NHS Payment System. Therefore, Public Health services have not been within the legislative scope of the NHS Payment System.

343. The Health and Care Act 2022 removed the prohibition on setting national payment rules for services commissioned by NHS England or an ICB in exercise of the Secretary of State's public health functions (as set out in section 7A or 7B of the National Health Service Act 2006). These services are subject to the NHSPS payment rules.' Therefore, Public Health services, including DES services are now subject to the same payment rules as other NHS services

344. Public Health Services, including the Diabetic Eye Screening Programme, will start to become part of the National Cost Collection (NCC).

345. The lack of a national price, and therefore a national default, for DES services has led to local price setting. This can lead to variation nationally in the price paid per screen, the cost per screen and the application of payment rules.

21.1 The currency model

346. There are four services being provided as part of the diabetic eye screening (DES) pathway in 2025/26:

- Routine Digital Screening
- Digital Surveillance without Optical Coherence Tomography (OCT)
- Digital Surveillance with Optical Coherence Tomography (OCT)
- Slit Lamp Biomicroscopy (SLB)

347. These services have the following local currencies. Guide prices for these currencies are set out in Annex DpA, tab 8.

Table 17: Currencies for Diabetic Eye Screening services

Local Service code	Local currency (non HRG) Name
NCBPH22A	Routine Digital Screening (RDS)
NCBPH22B	Digital Surveillance with OCT
NCBPH22C	Slit Lamp Biomicroscopy (SLB)

Local Service code	Local currency (non HRG) Name
NCBPH22D	Digital Surveillance without OCT

348. Beginning in October 2024, optical coherence tomography (OCT) has been phased in to the diabetic eye screening (DES) pathway for patients with diabetes who are at risk of diabetic retinopathy, with all providers expected to have implemented OCT by October 2025. Concurrently, commissioning responsibility for OCT as part of the screening pathway has been assumed by NHS England.

349. OCT scans take a high-resolution, three-dimensional image of the patient's retina, and can help to detect sight-threatening eye conditions such as glaucoma, diabetic retinopathy and macular degeneration up to four years earlier than traditional imaging methods.

350. This is anticipated to reduce the volume of unnecessary referrals (often due to false positives from less sensitive screening methods) from DES to hospital eye services (HES) for people in the digital surveillance pathway by up to 80%. There are currently no unit prices for OCT, or the DES pathway as a whole in the NHS payment scheme (NHSPS).

351. The rationale for developing prices for the pathway is to ensure providers are appropriately reimbursed for the service and avoid large variations in payments.

21.2 Considerations

352. Currently there are limited national costing and activity datasets for DES. Therefore, to set the non-mandated guide prices in this consultation current contract prices and a time and motion study has been used. The time and motion study and pre-consultation engagement with the sector led to the following weights with respect to the baseline price of Routine Digital Screening (RDS) being used in setting the non-mandated guide prices:

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

Table 18: Relative weights for Diabetic Eye Screening services

Local Service code	Local currency (non HRG) Name	Relative Weight
NCBPH22A	Routine Digital Screening (RDS)	1.00
NCBPH22B	Digital Surveillance with OCT	1.95
NCBPH22C	Slit Lamp Biomicroscopy (SLB)	n/a

Local Service code	Local currency (non HRG) Name	Relative Weight
NCBPH22D	Digital Surveillance without OCT	1.29

354. Data quality and variability exists within the information received to date.

355. This public consultation will allow NHS England to gather formal feedback to help inform further development work on setting a guide price for all activity in DES.

356. Throughout 2025/2026 NHS England will carry out an impact assessment on the non-mandated guide prices, taking into consideration feedback from the public consultation, impact on activity of 24-month screening intervals, OCT implementation in to the digital surveillance pathway and two tier grading. This will include ensuring the activity data flows are valid and complete to underpin this work.

Currencies with no NHS Payment Scheme prices

The currencies in this section do not have prices published in the NHS Payment Scheme. However, the currencies may still be useful for collecting costs and agreeing appropriate payments.

22. HIV adult outpatient services pathway currencies

357. 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.

358. 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.

22.1 The currency model

359. 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.

360. 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

Category 1: New patients
Category 1 patients are newly diagnosed in England and 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, from the date they start ARV treatment after which they will 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.
Category 2: Stable patients
Category 2 covers patients who do not have one of the listed Category 3 complexities and 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 require a greater level of care due to a number of complexities. such as:

- 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.

361. To support the currencies, the UK Health Security Agency (UKHSA) collects HIV surveillance data on 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.

362. Paediatric data is collected by the Children's HIV and AIDS reporting system (CHARS), and is shared with UKHSA on an annual basis.

363. 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.

23. Ambulance services

364. 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.

365. **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.

366. **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.

367. **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.

368. **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.

369. If 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*.

370. 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 NHS payment scheme, 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?

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

24. Wheelchair currencies

372. Providers currently submit some currency related data to the National Wheelchair Quarterly Collection via commissioners. As specified by the CSDS Information Standards Notices, wheelchair providers should also provide monthly patient level data to the Community Services Data Set (CSDS).

373. The currencies 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 below.

374. These services do not have NHSPS prices.

375. Building on the feedback from a wide range of stakeholders we developed currencies which fit into four categories:

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

376. The following sections summarise each currency.

24.1 Assessment of needs

377. 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.

378. 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 (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.

379. 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.

380. 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.

24.2 Provision of equipment

381. 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.

382. 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

383. 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.

384. 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.

385. 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.

24.3 Review

Review (WC11)

386. 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.

387. 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.

388. 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.

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

390. 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.

391. Not all services are commissioned to provide a review.

24.4 Repair and maintenance

392. 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.

393. 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.

394. 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)

395. 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)

396. 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 powered wheelchair users.

25. Spinal cord injury services

397. 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.

398. 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.

25.1 The currency model

399. 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.

400. 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.

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

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

402. 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.

403. 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.

404. 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.

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

406. 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.

407. 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.

Currencies for Community and Mental Health Care

26. Mental Health and Neurodevelopmental Resource Groups (MHNRGs)

408. The Payment Team and Mental Health Infrastructure Team are jointly developing currency models (MHNRGs) for mental health care. MHNRGs are a patient segmentation tool for providers and systems to plan, fund, benchmark and improve their services in a more evidence-based way. MHNRGs are a key lever for achieving parity of esteem with the acute sector, with better outcomes reporting and robust costing to demonstrate value for money and improve the quality of care for our patients. The currency model aims to support system based collaborative working based on national policy ambitions, creating a common understanding of care provision, and providing a standardised evidence-base which can support effective and equitable funding models.

409. MHNRGs have been developed with the input of expert working groups led by clinicians and patients, supported by an overarching steering group. These models aim to avoid additional clinical data burden and will instead be derived from clinical data stored locally and submitted through MHSDS in a generally automated process.

410. NHS England has published the following currency models for 2025/26:

- Psychosis and Bipolar Disorders (adults)
- Mood and Anxiety Disorders (adults)
- Neurocognitive Disorders (adults)
- Personality Disorders (adults)
- Eating and Feeding Disorders (all-age)
- Children and Young People

411. A further two groups have been identified for the purposes of identifying patients at a population level and are:

- Neurodevelopmental Disorders (all-age)
- Addiction, Alcohol and Substance Misuse (adults)

412. Additionally, a currency model has been developed for NHS Talking Therapies for Anxiety and Depression (previously Improving Access to Psychological Therapies (IAPT)).

What does this mean for providers?

413. Providers should ensure that the data items required to populate each currency model are collected and stored locally. Key data fields are set out on FutureNHS. As per

design, all data items can be submitted to national data sets, providers should ensure that this data is provided within current national data submissions.

414. Providers should begin to use currency data locally to support the planning of existing services and future care provision to understand population-based needs and how these needs can be met in collaboration with other local teams/providers. Needs and complexity factors should be used to understand population characteristics and put existing health disparities at the heart of service planning.

415. Providers are required to use currency models and associated data on a day-to-day basis as part of local benchmarking.

416. Providers should also use benchmarking to understand and monitor the impact and outcomes achieved across different cohorts such as ethnic minorities, using the needs and complexity factors.

417. Providers should use currency information as an evidence base to underpin and support an evidence-based approach to commissioning and contracting.

What does this mean for commissioners?

418. ICBs should expect providers to begin collecting currency related data as part of standard practice and using this data as defined above. Commissioners should begin to request currency related data as part of day-to-day working within local systems.

419. ICBs should begin to use currency models as part of planning processes across the system including needs and complexity factors to systematically reflect existing health disparities and the prevalence of complexities in population health planning.

420. ICBs should begin to use currency models as part of processes to evaluate service provision against the needs of local populations including to understand and monitor the impact and outcomes achieved across different cohorts.

421. ICBs should consider currency models for Mental Health Services when reviewing API fixed payments (see the *NHS provider payment mechanisms* supporting document).

Support and links

422. A mental health currencies guidance document has been published alongside the 2025/26 NHS Payment Scheme. This document provides guidance which sets out how the models were developed, defines the populations of each model and supports the implementation of the models.

423. NHS England continues to develop the currency models, for further information and tools, or to get involved in future development, please visit the Currency Models, Support and Guidance FutureNHS workspace.

27. Community Currency Development

424. The Community Currency Models are a key lever for achieving parity of esteem with the acute sector, supporting service planning and consistent benchmarking. The models support a fundamental shift towards an evidence-based methodology for understanding the needs of patients, the care that patients receive and the quality and value of care. They also provide a mechanism for informed commissioning decision-making as an evidence base.

425. The currency models aim to support system-based collaborative working based on national policy ambitions and are underpinned by high-quality source data which aims to minimise burden by using existing data wherever possible.

426. The currency models have been developed with the input of working groups led by clinicians, finance and commissioning colleagues, as well as other experts.

427. NHS England has published the following currency models for 2025/26:

- Frailty (adults)
- Last Years of Life (adults)
- Long Term Conditions (adults)
- Shorter Term Interventions (adults)
- Children and Young People – Long Term Conditions or Disabilities
- Children and Young People – Shorter Term Interventions
- Children and Young People – End of Life Care

What does this mean for providers?

428. Providers should ensure that the data items required to populate each currency model are collected and stored locally. Key data fields are set out on FutureNHS. As per design, all data items can be submitted to national data sets, providers should ensure that this data is provided within current national data submissions.

429. Providers should begin to use currency data locally to support the planning of existing services and future care provision to understand population-based needs and how these needs can be met in collaboration with other local teams/providers.

430. Providers are required to use of currency models and associated data on a day-to-day basis as part of local benchmarking.

431. Providers should use currency information as an evidence base to underpin and support an evidence-based approach to commissioning and contracting.

What does this mean for commissioners?

432. ICBs should expect providers to begin collecting currency related data as part of standard practice and using this data as defined above. Commissioners should begin to request currency related data as part of day-to-day working within local systems.

433. ICBs should begin to use currency models as part of planning processes across system and as part of processes to evaluate services provision against the needs of local populations.

434. ICBs should consider currency models for Community Services when reviewing when reviewing API fixed payments (see the *NHS provider payment mechanisms* supporting document).

Support and links

435. A community currencies guidance document has been published alongside the 2025/26 NHS Payment Scheme. This document provides guidance which sets out how the models were developed, defines the populations of each model and supports the implementation of the models.

436. NHS England continues to develop the currency models, for further information and tools, or to get involved in future development, please visit the Currency Models, Support and Guidance FutureNHS workspace.