2019/20 National Tariff Payment System: Annex C

Guidance on currencies without national prices

A joint publication by
NHS England and NHS Improvement

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Contents

1 Introduction

1. This document provides information and guidance on currencies specified in the 2019/20 National Tariff Payment System (21019/20 NTPS) that do not have national prices. It should be read alongside the relevant parts of Section 6 of the 2019/20 NTPS (local prices).

2. National tariff rules require that, where a national currency is specified for a service which does not have a national price, it must be used as the basis for local price-setting. Providers and commissioners can agree to move away from these currencies, in accordance with the relevant rules in the 2019/20 NTPS. See rules 3 and 4 in Section 6.4.

3. The national currencies without a national price considered in this document are:

   - critical care – adult and neonatal
   - dialysis for acute kidney injury
   - HIV adult outpatient services
   - renal transplantation
   - specialist rehabilitation
   - ambulance services
   - wheelchair services
   - spinal cord injury services
   - adult mental health services.

4. Annex A lists the HRGs for positron emission tomography and computed tomography (PET/CT).

2 Critical care – adult and neonatal

5. Critical care is a high cost, low volume service that requires intense management and intense monitoring of the patient using advanced nursing, therapy and medical skills. Critical care is a service that can occur in all admitted patient care and most of its activity is unplanned.

6. A critically ill patient can be defined as someone who immediately requires any form of organ support (intubation, ventilation, inotropes), or is likely to suffer acute cardiac, respiratory or neurological deterioration requiring such support.

7. The introduction of adult and neonatal critical care currencies has made it easier for providers and commissioners to agree activity and price levels.

2.1 The currency model

8. Commissioners and providers must contract for adult and neonatal critical care services using the healthcare resource group (HRG) currencies. These are based on the adult and neonatal critical care minimum datasets.

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

Table 1: HRG currencies for adult critical care

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

10. The HRGs for neonatal critical care services (subchapter XA) are descriptive rather than linked to a specific number of organs.

Table 2: HRG currencies for neonatal critical care

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

11. Due to the variation in critical care unit size, commissioners of smaller units may prefer a fixed and variable payment model to ensure capacity and availability of beds, whereas commissioners of larger units may prefer a per-patient payment model to incentivise efficiency or movement of beds to meet other strategies (eg major trauma). When adopting alternative payment approaches, providers must adhere to the general rules for local pricing and disclosure requirements in Section 6.4 of the 2019/20 NTPS (see rule 4 in particular).

3 Dialysis for acute kidney injury

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

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

4 HIV adult outpatient services pathway currencies

14. 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.

15. 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.

4.1 The currency model

16. 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 3. The currencies support an annual year-of-care payment approach.

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

Table 3: HIV adult outpatient currencies

HIV adult outpatient currencies
Category 1: New patients
Category 1 patients are newly diagnosed in England or have newly started on ARV drugs. In the first year of diagnosis these patients require more intensive clinical input than stable patients. This includes a greater number of more complex diagnostic tests and more frequent clinic visits with a greater input from multidisciplinary teams. A newly diagnosed patient will be a Category 1 patient for one year, after which they will automatically become a Category 2 patient, unless they start ARV drugs for the first time during the year. A patient starting ARV drugs for the first time will be a Category 1 patient for one year then they will automatically become a Category 2 patient. These events can immediately follow each other. For example, a patient may be newly diagnosed and then after seven months start ARV drugs. As a result, the patient would be in Category 1 for 19 months and then automatically become a Category 2 patient. If a patient is Category 1, but has one of the Category 3 listed complexities they become a Category 3 patient for a year.

HIV adult outpatient currencies

Category 2: Stable patients

Category 2 covers patients who do not have one of the listed Category 3 complexities and are either not on ARV drugs or started ARV drugs more than one year ago. This category covers most patients and therefore should be used as the default category unless Category 1 or 3 criteria can be shown and validated.

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

Category 3: Patients with complex needs

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

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

18. To support the currencies, Public Health England has introduced the HIV and AIDS reporting system (HARS). All organisations providing the HIV outpatient pathways must submit data to HARS. This dataset will support commissioning and epidemiology of HIV adult outpatient activity.

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

20. 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.[1]

[1] www.gov.uk/government/publications/hiv-outpatient-pathway-updated-guidance-available

5 Renal transplant

21. 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.

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

23. 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.

24. Non-mandatory prices have been set for renal transplant services to support the development of local prices. See the *Non-mandatory prices and currencies workbook* for details.

5.1 What is the renal transplant currency?

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

26. 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.

5.2 What does the pathway cover?

27. There are already HRGs relating to this activity: LA01A, LA02A, LA03A, LA10Z, LA11Z, LA12A, LA13A, LA14Z and LB46Z. There are also outpatient procedure codes: M171, M172, M173, M174 and M175.

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

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

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

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

30. 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.

5.3 What is included in the price?

31. The payments cover all outpatient and inpatient activity in the adult kidney transplant patient pathway and the live donor pathway. There are several phases associated with the pathway:

5.3.1 Transplant assessment

32. 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.

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

5.3.2 Live donor assessment

34. 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.

35. Outpatient activity will be captured by clinic 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/

5.3.3 Maintenance on the transplant list

36. This will include: one annual transplant-focused clinic appointment; three monthly H&I antibody measurements; list maintenance. It will be captured by outpatient 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.

5.3.4 The transplant episode

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

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

5.3.5 Live donor nephrectomy

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

5.3.6 Post-transplant follow-up.

40. 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.

41. 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 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.

5.3.7 Live donor follow-up

42. 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.

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

5.4 What is excluded from the price?

44. The following are explicitly not included:

- the consultation at which all modalities of renal replacement therapy are considered
- all immunosuppression drugs, CMV prophylaxis/treatment drugs and hepatitis B prophylaxis drugs that are on the NHS England list of directly commissioned drugs, as these will be funded by pass-through payments
- kidney transplants with simultaneous pancreas transplants, or other multi-organ transplants incorporating a kidney transplant

- deceased donor organ donation and costs related to the associated organ retrieval
- antibody incompatible (ABOi and HLAi) transplantation, but this will be included in future.

45. 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 will be covered by tariffs or prices assigned to the relevant HRG or treatment function code (TFC), eg cardiological assessment of potential transplant recipients.

46. 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 tariff. These episodes of care will be covered by the tariffs assigned to the relevant HRG or TFC, eg CT scan or coronary angiogram.

47. 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.

5.5 Drugs

48. 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.

49. 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/

50. 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 4: Summary of kidney transplant HRG codes and associated activity

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

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

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

6 Specialist rehabilitation

51. 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.

52. 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.

53. The non-mandatory weighted daily rate payment model has been designed to provide a fair and clearer payment approach for high cost specialised acute rehabilitation patients.

6.1 The currency model

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

55. 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).

56. 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.

57. During the patient's admitted stay on a specialist rehabilitation unit, clinicians must use the Rehabilitation Complexity Scale (RCS-Ev12) tool to assess the

[2] https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-pss-tools

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).

58. 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.

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

60. More detailed guidance on implementation and use of the WBD currency model has been prepared through the Clinical Reference Group for Specialist Rehabilitation.[3]

6.2 Non-mandatory guide prices

61. Following the publication of the 2017/19 NTPS, we have worked with commissioners and clinicians, through the National Casemix Office Expert Working Groups, the UK Rehabilitation Outcomes Collaborative (UKROC), and NHS England Specialised Commissioning clinical reference groups (CRGs) to set non-mandatory prices for 2019/20 (see *Non-mandatory currencies and prices workbook* for details).

62. Costs for specialist rehabilitation are not reported through reference costs, 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.

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

63. UKROC has updated the specialist rehabilitation costing model and provided up-to-date costing data. We have used the UKROC costing and activity data to set the non-mandatory prices for 2019/20.

7 Ambulance services

64. This section details the national currencies for ambulance services and what to include and exclude when applying these currencies. Any services not specified in these lists are not subject to a national ambulance currency.

65. **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.

66. **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.[4]

[4] www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

67. **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.

68. **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.

69. When considering local prices and departures from national currencies for ambulance services, providers and commissioners may wish to consider how they would support the ambitions set out in the Five Year Forward View[5] and Lord Carter's *Review of operational productivity and performance in English NHS ambulance trusts: unwarranted variation*.[6]

[5] www.england.nhs.uk/publication/nhs-five-year-forward-view/
[6] https://improvement.nhs.uk/about-us/corporate-publications/publications/lord-carters-review-unwarranted-variation-nhs-ambulance-trusts/

70. The following questions can be used to help inform the development of such a departure from the national currency:

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

8 Wheelchair currencies

71. The non-mandatory currencies for wheelchair services introduced in April 2017 will become national currencies from April 2019. Providers already report against these currencies to support commissioners to submit quarterly returns to NHS England. There are plans to expand the Community Services Dataset to include wheelchair information.

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

73. Non-mandatory prices for children and adult wheelchair services are provided in the document *Non-mandatory prices and currencies*.

74. The following sections summarise each currency.

8.1 Assessment currencies

75. Assessment is the process of determining which type of wheelchair and accessories a service user requires after being referred to a wheelchair service. The currency categories are:

- low need
- medium need
- high need (manual and powered)
- review.

76. Local prices will be based on clinician time to perform the assessment but in the case of review will include the cost of accessories.

8.2 Equipment currencies

77. The equipment currencies are based on the delivery of a complete ‘equipment package’ of the wheelchair, together with necessary cushions, seating systems, belts or harnesses, modifications and accessories.

- low need
- medium need
- high need (manual and powered).

78. Where users are deemed to have a higher level of need on any element of the equipment package, the provider would be reimbursed at that higher level of provision for the equipment package as a whole. For example, a basic chair with an enhanced pressure-relieving cushion would be costed at the medium level of complexity.

79. The provision of substantive additional accessories following delivery of the chair – eg replacement seat back, or upgrades to cushions – forms part of the review assessment currency.

80. Local prices should be agreed on the basis of average costs for each of the currencies, for appropriate:

- chair
- cushioning
- accessories
- occupational therapy technician or rehabilitation engineering time to perform modifications to the chair and fitting of accessories
- clinical time associated with checking of modifications and handover of equipment.

8.3 Repair and maintenance

81. The relative complexity of manual and powered chairs, cost base for parts, and the annual service or planned preventative maintenance required, result in different repair and maintenance currencies for each type of equipment:

- manual
- powered.

82. The currencies include:

- parts and labour for repair of wheelchairs
- delivery or collection of chairs to or from users
- costs associated with scrapping chairs at the end of their useful lifecycle
- annual planned preventive maintenance for power chair users.

83. Table 5 gives clear definitions for each category, which will help organisations to allocate activity against the currencies.

Table 5: Wheelchair currency categorisation and definition

Unit	Activity	Definition	Examples
Per care episode	Low need – assessment	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.
	Medium need – assessment	Higher allocation of clinical time including the use of more specialist time.	Daily users of wheelchair, or use for significant periods most days. Have some postural or seating needs. Physical condition may be expected to change (eg weight gain/loss; some degenerative conditions). Comprehensive, holistic assessment by skilled assessor required. Regular follow-up/review.
	High need: manual – assessment	This currency involves a higher allocation of clinical time than the medium currency. This also includes	Permanent users who are fully dependent on their wheelchair for all mobility needs. Physical condition may be expected to change/degenerate over time.

Unit	Activity	Definition	Examples
	High need: powered – assessment	the use of a higher and more specialist skillset of staff.	Very active users, requiring ultra-lightweight equipment to maintain high level of independence. Initial assessment for all children. Comprehensive, holistic assessment by skilled assessor required. Regular follow-up/review with frequent adjustment required/expected.
Per chair issued	Low need – equipment	A basic wheelchair package that includes a standard cushion and one accessory and modification.	Equipment requirements: Basic wheelchair (self or attendant-propelled)/standard cushion/up to one accessory/up to one modification.
	Medium need – equipment	A higher allocation of equipment and modifications.	Equipment requirements: Configurable, lightweight or modular wheelchair (self or attendant propelled)/low to medium pressure relieving cushions/basic buggies/ up to two accessories/up to two modifications.
	High need: manual – equipment	More complex and customised.	Equipment requirements: Complex manual or powered equipment, including tilt-in-space chairs, fixed-frame chairs Seating systems on different chassis/high pressure-relieving cushions/ specialist buggies/multiple accessories/multiple and/or complex modifications/needs are met by customised equipment.
	High need: powered – equipment		

Unit	Activity	Definition	Examples
Per registered user per year	All needs: manual – repair and maintenance	The tariff has assumed that services will be outsourced to a third party provider and taken as a reasonable proxy for efficient provider prices.	The unit cost for each chair can be calculated using the total repair and maintenance (R&M) budget against activity for the period. In calculating the average R&M unit cost per chair, please use a combination of low, medium and high needs categorisation. This only applies to manual wheelchairs.
	All needs: powered – repair and maintenance		
Per review	All needs – review	This involves the review of a patient.	This could be planned or via an emergency route when there is a change to a patient's condition or equipment. A review that results in the patient being provided with additional equipment or modification will incur a separate charge.
Per item	All needs – review substantial	A review followed by a modification/new accessory or resulting in a completely new follow-up assessment if a new wheelchair is required.	All needs – review substantial accessory (a review of existing equipment issued to the service user followed by a minor modification/ onward referral to R&M/new accessory (cushion or seat backs). If (as arising from the review) a complete new assessment or new wheelchair is required, this will be recorded in the assessment and equipment pathways as a new episode of care.
Per review	Specialised complex wheelchair services	More complex and customised.	Specialist suppliers who are performing the specialist modifications. Cost per chair, not per modification.
	Equipment, specialist modification without supply	This involves a review of the patient.	A higher allocation of equipment and modifications. Seating systems on different chassis/high pressure-relieving cushions/ specialist buggies/multiple accessories/multiple and/or complex modifications/needs are met by customised equipment/personalised adjustment. Wheelchair not supplied.

9 Spinal cord injury services

84. 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.

85. 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.

86. The management of patients with SCI has evolved, and there is a need to move towards setting a nationally mandated currency for this service to improve consistency in service delivery and patient outcomes and provide a platform for future costing.

9.1 The currency model

87. 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.

88. 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.

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

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

90. 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.

91. 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.

92. 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.

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

94. 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.

95. 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.

10 Adult mental health services

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

10.1 Services for working age adults and older people

97. Local pricing rule 7(a) states that providers and commissioners must adopt a blended payment approach for mental health services for working-age adults and older people, unless they agree an alternative approach (rule 7(b)). Mental health clusters are the underpinning currencies to support the development of a blended payment approach. Clusters group people according to their needs under three broad diagnostic categories – psychotic, non-psychotic and organic. They provide a framework for planning and organising mental health services and the care and support provided to individuals. There are 21 clusters (see Table 6). Each patient is assessed based on their symptoms and individual need. The clusters allow for a degree of variation in the combination and severity of rated needs. For more details of the clusters, see Annex E: Mental health clustering tool.

Table 6: Mental health care cluster currencies

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

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

10.2 IAPT services

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

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

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

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