2020/21 National Tariff Payment System – a consultation notice

Annex DtB: Guidance on currencies with national prices

December 2019
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1 Introduction

1. This document is Annex DtB of the consultation notice on proposals for the 2020/21 National Tariff Payment System (2020/21 NTPS). It contains further information and guidance on certain currencies for services with national prices. It is proposed that this document would, as an annex, form part of the 2020/21 NTPS on publication. It should be read alongside the proposed currency descriptions in Section 3 and Annex DtA of the draft 2020/21 NTPS.

2. In the 2020/21 NTPS we are proposing to introduce a blended payment for outpatient attendances (see Section 6 of the consultation notice). This would mean that outpatient attendances are removed from the scope of national prices. As such, detailed guidance on the currencies for outpatient attendances is included in the supporting document Guidance on blended payments.
2 Diagnostic imaging

3. Separate diagnostic imaging national prices are set for services done in an outpatient setting for which there are unbundled HRGs in subchapter RD. These services are:
   a. magnetic resonance imaging scans
   b. computed tomography scans
   c. dual energy X-ray absorptiometry (DEXA) scans
   d. contrast fluoroscopy procedures
   e. non-obstetric ultrasounds
   f. nuclear medicine
   g. simple echocardiograms.

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

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

2.1 Where diagnostic imaging costs remain included in national prices

6. Diagnostic imaging does not attract a separate payment in the following instances:
   a. where the patient data groups to a procedure-driven HRG with a national price (that is, not from HRG4+ subchapter WF)
   b. where the national price is zero (eg LA08E, SB97Z and SC97Z, which relate only to the delivery of renal dialysis, chemotherapy or external beam radiotherapy), any diagnostic imaging is assumed to be connected to the outpatient attendance
   c. where diagnostic imaging is carried out during an admitted patient care episode or during an A&E attendance
d. where imaging is part of a price for a pathway or year of care (eg the best practice tariff for early inflammatory arthritis)

e. where imaging is part of a specified service for which a national price has not been published (eg cleft lip and palate).

7. 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.

2.2 Processing diagnostic imaging data

8. It is expected that providers will use Secondary Uses Service (SUS)^1 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 national price, the scan must be excluded from charging.

9. The Terminology Reference-data Update Distribution Service (TRUD)^2 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.

10. 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.

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^1 The SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. Further detail is available at: http://digital.nhs.uk/sus

^2 https://isd.hscic.gov.uk/trud3/user/guest/group/0/home
11. 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.

12. 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:

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

   b. If the diagnostic imaging occurs on a different day from the outpatient activity, the scan can be assumed to be related to the first attendance on the day the scan was requested.

13. 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 with a national price (that is, not from HRG4+ subchapter WF).

14. 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.

15. 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.
3 Chemotherapy and radiotherapy

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

3.1 Chemotherapy delivery

17. Chemotherapy is split into two parts:

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

b. the unbundled HRG for chemotherapy delivery.

18. From 2020/21, the procurement HRGs are no longer currencies specified with national prices and there is no requirement to collect data on them. We are working with NHS England and NHS Improvement Specialised Commissioning to support all providers to move to pass through payments for chemotherapy drugs. The majority of providers are already using the pass through approach.

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

20. The cost of the delivery HRGs includes the cost of supportive drugs listed on the NHS England and Improvement chemotherapy supportive drugs list.³

Table 1: Chemotherapy delivery HRGs (not including oral administration)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver simple parenteral chemotherapy</td>
<td>Overall time of 30 minutes nurse time and 30 to 60 minutes chair time for the delivery of a complete cycle.</td>
</tr>
<tr>
<td>Deliver more complex parenteral chemotherapy</td>
<td>Overall time of 60 minutes nurse time and up to 120 minutes chair time for the delivery of a complete cycle.</td>
</tr>
</tbody>
</table>

### Table 2: Payment arrangements for chemotherapy HRGs

<table>
<thead>
<tr>
<th>Core HRG</th>
<th>Unbundled chemotherapy delivery HRG</th>
</tr>
</thead>
</table>
| Ordinary admission | eg LB35B  
National price includes cost of delivery  | No HRG generated |
| Day case and outpatient | SB97Z (generated if no other activity occurs)  | eg SB14Z  
National prices |
| Day case and outpatient | If other activity occurs, eg LB35B  | eg SB14Z  
National prices |
| Regular day and regular night admissions | As per day case and outpatient  | eg SB14Z  
National prices |

21. 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:

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

22. 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.

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

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

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

3.2 External beam radiotherapy

25. Radiotherapy can be split into two broad areas:
   a. external beam radiotherapy
   b. brachytherapy and molecular radiotherapy administration.

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

27. The radiotherapy HRGs are similar in design to the chemotherapy HRGs in that an attendance may result in more than one HRG; that is, both preparation and treatment delivery. The national radiotherapy dataset (RTDS), introduced in 2009, must be used by all organisations providing radiotherapy services.
28. It is expected that, in line with the RTDS and clinical guidance, external beam radiotherapy treatment will be delivered in an outpatient setting. Patients do not need to be admitted to receive external beam (teletherapy) radiotherapy.

**Table 4: Payment arrangements for external beam radiotherapy**

<table>
<thead>
<tr>
<th>Core HRG</th>
<th>Unbundled radiotherapy planning HRG (one coded per course of treatment)</th>
<th>Unbundled radiotherapy delivery HRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordinary admission</td>
<td>National price applies</td>
<td>Treat as per RTDS (radiotherapy treatment delivered as outpatient)</td>
</tr>
<tr>
<td>Day case and outpatient</td>
<td>SC97Z (generated if no other activity occurs)</td>
<td>eg SC45Z HRG generated National prices</td>
</tr>
<tr>
<td>Regular day and regular night admissions</td>
<td>As per day case and outpatient</td>
<td>eg SC45Z HRG generated National prices</td>
</tr>
</tbody>
</table>

29. As in previous years, the unbundled HRG SC97Z attracts a zero (£0) price when a patient has attended solely for external beam radiotherapy. This removes the need for organisations to adjust local payment arrangements for radiotherapy to take account of the core HRG for the diagnosis. SC97Z is generated where:

a. external beam radiotherapy has taken place

b. the activity has a length of stay less than one day

c. the core HRG which would otherwise be generated is a diagnosis-driven HRG (with no major procedures taking place).

30. Planning codes do not include the consultation at which the patient consents to radiotherapy nor any outpatient attendance for medical review required by any change in status of the patient. These activities would generate an outpatient HRG.
31. Delivery codes will be assigned to each attendance for treatment (only one fraction [HRG] per attendance will attract a national price). The only exception to this rule is if two different body areas are being treated when a change in resources is identified, rather than treating a single site. Hyperfractioned radiotherapy, involving two doses delivered six hours apart, would generate two delivery attendances.

32. 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\(^4\) will attract a national price.

\(^4\) For a definition of ‘episode’, see the NHS Data Model and Dictionary at www.datadictionary.nhs.uk/web_site_content/navigation/main_menu.asp
4 Post-discharge rehabilitation

33. The post-discharge national prices were first introduced in 2012/13 to encourage a shift of responsibility for patient care after discharge to the acute provider that treated the patient. This was in response to increasing emergency readmission rates in which many patients were being readmitted to providers after discharge.

34. There are four post-discharge national prices that must be used where a single trust provides both acute and community services. Other providers may choose to use these prices. The post-discharge prices cover four areas of care:
   
a. cardiac rehabilitation
b. pulmonary rehabilitation
c. hip replacement rehabilitation
d. knee replacement rehabilitation.

35. There are associated commissioning packs for cardiac rehabilitation\(^5\) and pulmonary rehabilitation.\(^6\)

4.1 Cardiac rehabilitation

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

37. The currency is based on the care pathway outlined in the commissioning pack on cardiac rehabilitation. Commissioners must pay the national price even where the provider offers a different care pathway. The provider bears the risk

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

38. Based on clinical guidance, the post-discharge price will only apply to the subset of patients identified in the commissioning pack as potentially benefiting from cardiac rehabilitation, where the evidence for the effect of cardiac rehabilitation is strongest; that is, patients discharged having had an acute spell of care for:

a. acute myocardial infarction
b. percutaneous coronary intervention or heart failure
c. coronary artery bypass grafting.

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

a. acute myocardial infarction: a spell primary diagnosis of I210, I211, I212, I213, I214, I219, I220, I221, I228 or I229
b. percutaneous coronary intervention or heart failure: a spell dominant procedure of K491, K492, K493, K494, K498, K499, K501, K502, K503, K504, K508, K509, K751, K752, K753, K754, K758 or K759

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

4.2 Pulmonary rehabilitation

41. Post-discharge care for patients referred to pulmonary rehabilitation courses will be the responsibility of the integrated provider trust from which the patient is discharged. Any post-discharge activity outside a defined pulmonary rehabilitation pathway for these patients during the period of rehabilitation will remain the funding responsibility of the patient’s commissioner and is not covered by this price. The currency is based on the care pathway outlined in the
Department of Health commissioning pack for chronic obstructive pulmonary disease (COPD).\(^7\) Commissioners must pay the national price even where the provider offers a different care pathway. The provider bears the risk of the patient being readmitted and it is for them to assess what type of rehabilitation is provided and how it is provided.

42. The post-discharge price will apply to patients discharged having had an acute episode of care for COPD. The national price can be paid only for patients discharged from acute care with an HRG for the spell of care of DZ65A to DZ65K, who subsequently complete a course of pulmonary rehabilitation. The commissioning pack provides detailed guidance on the evidence base for those discharged from a period of care for COPD who will benefit from pulmonary rehabilitation.

4.3 Hip replacement rehabilitation

43. 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.

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

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

45. The national price applied therefore represents the funding for this rehabilitation pathway and will act as a maximum level of post-discharge rehabilitation payment. Local agreement will need to be reached on the price when integrated provider trusts take responsibility for post-discharge rehabilitation for patients who, after clinical evaluation, require less intensive rehabilitation pathways. The post-discharge price will fund the pathway for the first three months after discharge and does not cover long-term follow-up treatment.

\(^7\) www.gov.uk/government/publications/commissioning-toolkit-for-respiratory-services
46. The national price can only be paid for patients discharged from acute care with an episode of care with a spell dominant procedure of W371, W381, W391, W931, W941 or W951.

4.4 Knee replacement rehabilitation

47. 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.

48. The defined clinical pathway for post-discharge activity for primary non-trauma total knee replacements, suggested by clinical leads, contains:
   a. 10 nurse/physiotherapist appointments
   b. one occupational therapy appointment
   c. consultant-led clinic visits.

49. The national price applied therefore represents the funding for this rehabilitation pathway and will be the maximum post-discharge rehabilitation payment. Local agreement will need to be reached on the price (in accordance with local pricing rules) when integrated provider trusts take responsibility for post-discharge rehabilitation for patients who, after clinical evaluation, require less intensive pathways of rehabilitation. The post-discharge price will fund the pathway for the first three months after discharge and does not cover long-term follow-up treatment.

50. The national price can be paid only for patients discharged from acute care with an episode of care with a spell dominant procedure coding of W401, W411, W421 or O181. The post-discharge currencies for hip and knee replacement cover the defined clinical pathway only for post-discharge activity.
5 Cystic fibrosis pathway payment

51. 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.

52. 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).

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

54. The pathway payments cover all treatment directly related to cystic fibrosis for a patient during the financial year. This includes:
   a. admitted patient care and outpatient attendances (whether delivered in a specialist centre or under shared network care arrangements)
   b. home care support, including home intravenous antibiotics supervised by the CF service, home visits by the multidisciplinary team to monitor a patient’s condition, eg management of totally implantable venous access devices (TIVADs), collection of mid-course aminoglycoside blood levels and general support for patient and carers
   c. intravenous antibiotics provided during inpatient spells
   d. annual review investigations.

55. For any patient admission or outpatient contact in relation to cystic fibrosis, the HRG is included in the year-of-care payment regardless of whether it is one of the CF-specific diagnosis-driven HRGs or not. All outpatient CF activity must be recorded against TFC 264 and TFC 343.

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8 https://www.cysticfibrosis.org.uk/the-work-we-do/uk-cf-registry#
56. Some elements of services included in the CF pathway payments may be provided by community services and not the specialist CF centre: for example, home care support, including home intravenous antibiotics supervised by the cystic fibrosis service, home visits by the multidisciplinary team to monitor a patient’s condition (e.g., management of TIVADs) and collection of mid-course aminoglycoside blood levels. In such cases the relevant parties will need to agree on payment from the prices paid to the specialist CF centre.

57. There are some specified services that require local negotiation on price:
   
a. high cost CF-specific inhaled/nebulised drugs: colistimethate sodium, tobramycin, dornase alfa, aztreonam lysine, ivacaftor and mannitol.

b. insertion of gastrostomy devices (percutaneous endoscopic gastrostomy – PEG) and insertion of TIVADs are not included in the annual banded prices. These surgical procedures will be reimbursed via the relevant HRG price.

c. Neonates admitted with meconium ileus who are subsequently found to have cystic fibrosis will not be subject to the cystic fibrosis pathway payment until they have been discharged after their initial surgical procedure. This surgical procedure will be reimbursed via the relevant HRG price. Once discharged after their initial surgical procedure, subsequent cystic fibrosis treatment will be covered by the cystic fibrosis pathway payment. Annual banding will not include the period they spent as an admitted patient receiving their initial surgical management.

58. 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.
6 Looked after children health assessments

59. Looked after children\(^9\) 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.

60. Arrangements for commissioning and carrying out health assessments for children placed out of area can be variable, resulting in concerns over the quality and scope of assessments. To address this, a currency was devised and mandated for use in 2013/14, including a checklist for the components that must be included in the assessment.

61. The checklist tool must be completed by the health assessor and sent to the responsible commissioner or designated professional. It will be reviewed by the responsible commissioner or designated professional to support payment against the agreed quality. This checklist is set out in Table 5.

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

63. CCGs should commission providers in the area where the child has been placed to carry out the health assessments. This is because the doctor or nurse who carries out the assessment often becomes the lead professional, coordinating all health issues relating to that child’s care. Providers in the CCG where the child has been placed will have knowledge of and be able to access any local health services required following the health assessment.

64. For more guidance on relevant roles and competences of healthcare staff see the 2015 document *Looked after children: knowledge, skills and competences of health care staff, Intercollegiate role framework*,\(^10\) published by the Royal College of Nursing, Royal College of General Practitioners and the Royal College of Paediatrics and Child Health.

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\(^9\) [www.rcpch.ac.uk/resources/looked-after-children-lac](http://www.rcpch.ac.uk/resources/looked-after-children-lac)

\(^10\) [www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge__skills_and_competence_of_healthcare_staff.pdf](http://www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge__skills_and_competence_of_healthcare_staff.pdf)
**Table 5: Looked after children health assessment checklist tool**

<table>
<thead>
<tr>
<th>Child’s name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS number</td>
<td></td>
</tr>
</tbody>
</table>

| Date of health assessment |  |
| Date of request for health assessment |  |
| Assessment completed by: |  |

<table>
<thead>
<tr>
<th>Qualification:</th>
<th>Nurse</th>
<th>Midwife</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competent to level 3 of the Intercollegiate Competency Framework</td>
<td>Yes</td>
<td>No</td>
<td>Please delete as appropriate</td>
</tr>
</tbody>
</table>

**Section 2**

The summary report and recommendations should be typed and include:
- Pre-existing health issues
- Any newly identified health issues
- Recommendations with clear timescales and identified responsible person
- Evidence that referrals to appropriate services have been made
- A chronology or medical history including identified risk factors
- An up-to-date immunisation summary
- Summary of child health screening
- Any outstanding health appointments

**Section 3**

Child or young person’s consent for assessment (where appropriate)

Where the young person is over 16 years old written consent has been obtained for release of GP summary records, including immunisations and screening to a third party

Evidence that the child or young person was offered the opportunity to be seen alone

Evidence that child or young person’s concerns/comments have been sought and recorded
65. Please also see the following guidance:

   a. *Promoting the health and wellbeing of looked after children: revised statutory guidance*\(^{11}\)

   b. *Who pays? Determining responsibility for payment to providers.*\(^{12}\)

