

2015/16 National Tariff Payment System: A consultation notice

Annex 7a: Specified acute services for local pricing

26 November 2014

Annex 7a: Specified acute services for local pricing

This annex gives more detail on the nationally specified currencies for acute services with no national price. These currencies should be used in local price-setting for these services, unless an alternative approach is agreed in accordance with subsection 7.4.2 of the '2015/16 National Tariff Payment System'. This annex covers national currencies in the following areas:

- cochlear implants
- complex therapeutic endoscopy
- critical care – adult and neonatal
- dialysis for acute kidney injury
- HIV adult outpatient services
- positron-emission tomography and computed tomography (PET/CT)
- renal transplantation
- specialist rehabilitation.

Cochlear implants

This activity will have national currencies for use in 2015/16 (Healthcare Resource Groups [HRGs] CZ25A [unilateral] and CZ25B [bilateral]). We have not set a national price but a non-mandatory price will be available for use in 2015/16.

Complex therapeutic endoscopy

We are introducing a new HRG (FZ89Z) for complex therapeutic endoscopy. Activity for this HRG can be identified using combinations of procedure codes. Most of the activity that will be covered by the new HRG was previously mapped to HRGs FZ24A/B/C/D (major therapeutic open or endoscopic procedures). We have not set a national price but a non-mandatory price will be available for use in 2015/16.

Critical care – adult and neonatal

Critical care is a high cost and 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 apply in all admitted patient care and most of its activity is unplanned.

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

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

The currency model

Commissioners and providers must contract for adult and neonatal critical care services using the HRG currencies. These are based on the adult and neonatal critical care minimum datasets.

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

Table 7a.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

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

Table 7a.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

Due to the national 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 set out in Section 7.

Dialysis for acute kidney injury

In 2014/15 we introduced four new HRGs (LE01A, LE01B, LE02A and LE02B) for dialysis for acute kidney injury. 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.

We have not set a national price but a non-mandatory price will be available for use in 2015/16 for haemodialysis for acute kidney injury – LE01A and LE01B. Peritoneal dialysis for acute kidney injury (LE02A and LE02B) has a national currency.

HIV adult outpatient services pathway currencies

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.

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 into account ongoing changes in service delivery.

The currency model

The HIV outpatient currencies are a clinically designed pathway for each of three groupings of HIV adult patients (18 years and older) that supports an annual year-of-care payment approach.

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

Table 7a.3: HIV adult outpatient currencies

Category 1: New patients
<p>Category 1 patients are newly diagnosed in England or have newly started on ARV drugs.</p> <p>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.</p> <p>A newly diagnosed patient will be a category 1 patient for one year, after which they will automatically become a category 2 patient.</p> <p>Similarly, a patient starting ARV drugs for the first time will be a category 1 patient for one year when they will automatically become a category 2 patient.</p> <p>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.</p> <p>If a patient is category 1, but has one of the category-3-listed complexities they become a category 3 patient for a year.</p>
Category 2: Stable patients
<p>Category 2 covers patients that 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.</p> <p>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.</p>
Category 3: Patients with complex needs
<p>Patients who fall into category 3 need high levels of maintenance, or are highly dependent patients. Complexities are:</p> <ul style="list-style-type: none">• 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.

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

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

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](#).¹

Positron-emission tomography and computed tomography (PET/CT)

This activity will have a national currency for use in 2015/16 (HRG RA42Z – nuclear medicine category 8).

Renal transplant

Kidney transplantation is the renal replacement therapy of choice for patients with chronic kidney disease stage 5 who are considered to be 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.

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

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.

¹ <https://www.gov.uk/government/publications/hiv-outpatient-pathway-updated-guidance-available>

The currency model

An adult renal transplant currency (18 years and older) uses HRGs to collect activity and covers all care directly related to the preparation and provision of a transplant episode. This includes living donation and required post-transplant care delivered in both transplant and specialist renal centres.

This currency does not apply to kidney transplants with simultaneous pancreas transplants, or other multi-organ transplants incorporating a kidney transplant.

The currency covers activity relating to specific HRGs in use, but does not capture:

- antibody-incompatible transplant
- any deceased donor organ donation and costs related to the associated organ retrieval (the responsibility of NHS Blood and Transplant)
- outpatient attendances where the primary purpose is to formally assess suitability for transplant.

This care pathway provides the opportunity to include multiple elements within the currency without incentivising multiple outpatient visits, and the ability to include elements, and in particular tissue typing, which do not easily map to an outpatient attendance.

The currency is made up of three components:

- preparation for transplant outpatient attendances
- the transplant episode including post-discharge drugs
- post-transplant outpatients.

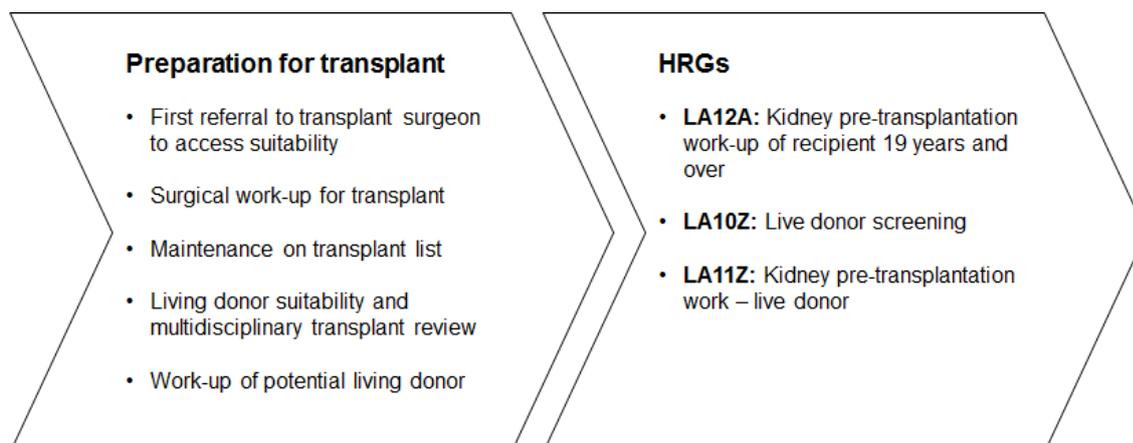
Preparation for transplantation

Pathway starts **after** a patient has been identified as potentially suitable for transplant and a nephrologist makes a formal outpatient referral to a transplant surgeon. The first outpatient consultation to further assess suitability for transplant with a transplant surgeon is the start of the pathway under this currency.

All adult pre-transplant outpatient activity related to both recipient and any potential living donor must be reported against the HRGs, each time each patient is seen in an outpatient clinic. This also includes outpatient activity while patients are on the transplant list.

Figure 7a.1 sets out the activities related to this component of the pathway and the HRGs to be used.

Figure 7a.1: Preparation for transplant

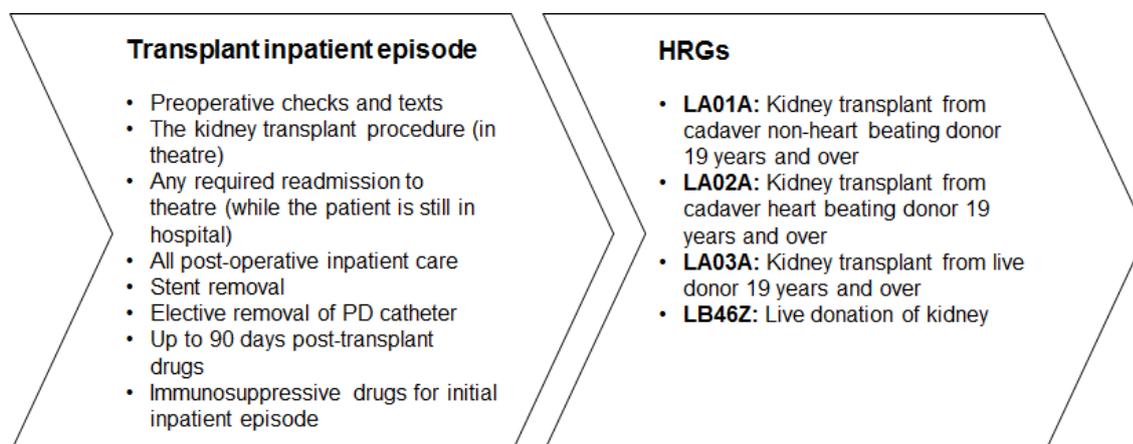


Transplant inpatient episode

The mandatory HRGs cover all activities during the transplant episode.

Figure 7a.2 sets out the activities related to this component of the pathway and the HRGs to be used.

Figure 7a.2: The transplant episode

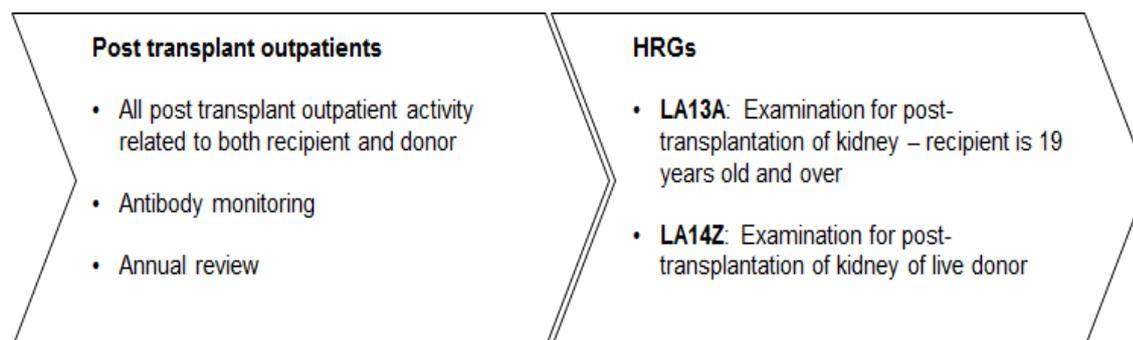


Post-transplant outpatients

All adult post-transplant outpatient activity, related to both recipient and donor, must be reported against the HRG every time the patient is seen in an outpatient clinic.

Figure 7a.3 sets out the activities related to this component of the pathway and the HRGs to be used.

Figure 7a.3: Post-transplant outpatient HRGs



Specialist rehabilitation

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.

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.

The weighted daily rate payment model has been designed to provide a fair and clearer payment approach for high cost rehabilitation patients.

The currency model

The currency model was first mandated in the 2013/14 PbR guidance. It designates providers into levels of specialist rehabilitation services.² These service levels have different service profiles and differing costs. Patient characteristics and needs are defined using the Specialised Services National Definition Set (SSNDS) for Rehabilitation.³ The same definitions are laid out in the NHS England service specification for Specialised Rehabilitation for patients with highly complex needs.⁴

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

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.

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).

In 2015/16, the UK specialist Rehabilitation Outcomes Collaborative (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 2a 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.

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

² <http://www.kcl.ac.uk/lsm/research/divisions/cicelysaunders/index.aspx>

³ <http://www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf>

⁴ <http://www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf>

More detailed guidance on implementation and use of WBD currency model has been prepared through the Clinical Reference Group for Specialist Rehabilitation.⁵

Indicative reference prices

[We intend to update these indicative reference prices for the final publication of the '2015/16 National Tariff Payment System']

The prices for hyperacute, physical, mixed and 2a activity are based on the published 2013/14 non-mandatory prices. These prices were developed through a cost collection exercise from providers who were already submitting patient data to UKROC.

These prices have **not** been adjusted for the 2015/16 cost uplifts and efficiency requirement.

The prices for 2b activity are also based on the 2013/14 non-mandatory prices. NB: The prices for 2b were recalculated after removing some activity that was outside the scope of the currency model.

The reference prices in Table 7a.4 have **not** been adjusted for the 2015/16 cost uplifts and efficiency requirement.

Table 7a.4: Specialist rehabilitation reference prices

		Level 1 services			Level 2 services	
		Hyperacute	Physical	Mixed	2a	2b
RCS-E complexity score	Provider type					
	Very high	655	617	601	578	521
	High	509	479	466	454	409
	Medium	391	368	358	331	298
	Low	318	299	291	231	208
	Very low	245	231	224	206	186

⁵ <http://www.csi.kcl.ac.uk/commissioning-tools.html>