Department
of Health

Reference costs guidance for 2013-14

A draft for NHS feedback

November 2013

Contents

Feedback **6**
Section 1: Introduction **7**
Purpose and context 7
Intended users 7
Essential resources 8
Costing principles and standards 9
Main changes for 2013-14 10
Supporting the development of price setting, and the development of the scope and design of currencies 10
Collecting high quality and relevant data 13
Minimising the administrative burden of national data collections 15
Scope 16
Timetable 18
NHS Data Model and Dictionary 19
Treatment function codes 19
Healthcare resource groups 20
Primary classifications 20
Queries 21
Section 2: Data quality, validation and assurance **22**
Introduction 22
Mandatory validations 23
Non-mandatory validations 23
Resubmissions of data 25
Self-assessment quality checklist 25
Board approval and Finance Director sign off 27
External assurance 28
Section 3: Admitted patient care **29**
Introduction 29
FCE costs 29
Ordinary non-electives 29
Excess bed days and trim points 29
Regular day or night admissions 30
Devices 30
Drugs 31
Obstetrics and maternity admitted patient episodes 32
Renal transplantation 33
Spell costs 33
Section 4: Outpatient services **34**
Introduction 34
Outpatient attendances 34
First and follow up 35
Face to face and non face to face 35
Single and multi-professional 36
Consultant led and non consultant led 36
HIV and AIDS 37
Maternity outpatients and scans, screens and tests 38
Paediatric treatment function codes 39
Sexual and reproductive health services 39
Therapy services 39

Procedures in outpatients ... 39
Cancer multi-disciplinary teams ... 39
Section 5: Emergency medicine ... 41
Section 6: Unbundled services ... 42
Introduction ... 42
Chemotherapy ... 42
Ordinary admissions ... 44
Day case and regular day or night admissions ... 44
Outpatients ... 44
Other settings ... 45
Additional guidance on chemotherapy ... 45
Critical care ... 46
Adult critical care ... 46
Critical care periods ... 47
Costing critical care ... 48
Paediatric critical care ... 48
Neonatal intensive care ... 51
Diagnostic imaging ... 51
Admitted patient care ... 52
Outpatients ... 53
Direct access ... 53
Other settings ... 53
High cost drugs ... 53
Radiotherapy ... 54
Rehabilitation ... 55
Admitted patient care ... 56
Outpatients ... 57
Complex specialised rehabilitation services ... 57
Specialist rehabilitation services ... 58
Non-specialist rehabilitation services ... 58
Costing rehabilitation services ... 58
Specialist palliative care ... 59
Ordinary admissions ... 59
Day case and regular day or night attenders ... 59
Outpatients ... 59
Section 7: Renal dialysis ... 61
Introduction ... 61
Renal dialysis for chronic kidney disease ... 61
Haemodialysis ... 61
Dialysis away from base ... 62
Peritoneal dialysis ... 62
Renal dialysis for acute kidney injury ... 62
Costing renal dialysis ... 62
Section 8: Direct access services ... 64
Introduction ... 64
Diagnostic services ... 64
Pathology services ... 64
Section 9: Mental health services ... 66
Introduction ... 66
Adult mental health services ... 67
Mental health care clusters ... 67
Costing the mental health care clusters ... 69

Child and adolescent mental health services 72
Drug and alcohol services 72
Specialist mental health services 72
Secure mental health services 73
Settings for non-cluster activity 73
Ordinary elective and non-elective admissions 73
Day care facilities 74
Outpatient attendances 74
Community contacts 75
Mental health specialist teams 76
Section 10: Community services 77
Introduction 77
Definitions 78
Allied health professionals 79
Health visitors and midwifery 80
Health visitors 80
Midwifes 81
Medical and dental services 81
Community dental services 81
Community paediatric services 81
Nursing 81
Specialist nursing services 81
Nursing services for children 83
District nursing services 84
School based children's health services 84
Audiology services 85
Assessment 85
Fitting 86
Hearing aid 86
Follow-up 86
Aftercare 86
Neonatal screening 87
Other audiology services 87
Day care facilities 87
Health promotion programmes 88
Intermediate care services 88
Wheelchair services 90
Assessment currencies 91
Equipment currencies 91
Repair and maintenance currencies 92
Section 11: Ambulance services 93
Introduction 93
Currencies 93
Calls 93
Hear and treat or refer 93
See and treat or refer 94
See and treat and convey 94
Section 12: Cystic fibrosis 95
Introduction 95
Year of care currencies 95
Part year of care 96
Network care 96

Costing cystic fibrosis 97
Section 13: Services excluded from reference costs 99
Section 14: Reconciliation 107
Introduction 107
Non-patient care activities 108
Reconciliation worksheet 109
Drugs and devices 114
Survey 114
Annex A: Submission deadlines 118
Annex B: Renal transplantation 123
Introduction 123
Preparation for transplantation 124
Transplant inpatient episodes 124
Post-transplantation outpatients 125

Feedback

We would welcome comments on this draft guidance. In particular, we would appreciate comments on the following questions:

Question 1: Do you provide any other specialist mental health service not currently collected in reference costs?

Question 2: Do you have any comments on our proposals for community services in reference costs?

Question 3: Do you have a service delivery model for orthotic, prosthetic or other community services that we should consider before collecting reference costs for these services?

Question 4: Do you have any comments on our proposals for collecting reference costs for intermediate care services?

Question 5: Do you support the further differentiation of adult critical care costs by all critical care unit functions?

Question 6: Do you have any comments on our changes to the national list of services excluded from reference costs?

Question 7: Do you have any comments on our revisions to the non-mandatory validations?

Question 8: Would you be able to exclude costs rather than net off income relating to research and development in 2013-14?

Please provide comments using the response form on our website and return it to pbrdatacollection@dh.gsi.gov.uk by **5pm on Friday 13 December 2013**.

We will consider your comments as we finalise the guidance for publication in early 2014.

Section 1: Introduction

Purpose and context

1. This guidance forms chapter 3 of Monitor's *Approved Costing Guidance 2013-14*[1], which brings together NHS costing and cost collection guidance into a single framework as follows:

Chapter 1: Costing principles – high-level principles that support all NHS costing exercises

Chapter 2: Costing standards – the *Clinical Costing Standards 2014-15*[2] for acute and mental health, to be published by the Healthcare Financial Management Association (HFMA) in early 2014

Chapter 3: Reference costs guidance – this guidance, which supersedes reference costs guidance issued in previous years and sets out the mandatory requirements for the collection of 2013-14 reference costs from NHS trusts and NHS foundation trusts. Reference costs are the average unit cost to the NHS of providing defined services in a given financial year to NHS patients in England and are collected annually by the Department of Health

Chapter 4: PLICS collection guidance – guidance to support the collection of 2013-14 patient level costs by Monitor.

Intended users

2. Table 1 provides a guide to which trusts should read each section of this guidance.

Table 1: Intended users

Section	Contents	Acute	Mental health	Community	Ambulance
1	**Introduction** Essential information to help trusts prepare for the 2013-14 collection.	✓	✓	✓	✓
2	**Data quality, validation and assurance** Required reading for all trusts	✓	✓	✓	✓
3	**Admitted patient care**	✓	✓	✓	
4	**Outpatient services**	✓	✓	✓	
5	**Emergency medicine**	✓	✓	✓	
6	**Unbundled services**	✓	✓	✓	
7	**Renal dialysis**	✓			
8	**Direct access services**	✓	✓	✓	

[1] http://www.monitor-nhsft.gov.uk/costingpatientcare
[2] http://www.hfma.org.uk/costing

Section	Contents	Acute	Mental health	Community	Ambulance
9	**Mental health services**	✓	✓	✓	
10	**Community services**	✓		✓	
11	**Ambulance services**				✓
12	**Cystic fibrosis**	✓			
13	**Services excluded from reference costs** Required reading for all trusts.	✓	✓	✓	✓
14	**Reconciliation** Essential information about reconciling reference costs to the final signed accounts. Required reading for all trusts.	✓	✓	✓	✓

Essential resources

3. Trusts will also need the following resources when preparing and submitting their reference costs:

Unify2[3] – the Department's corporate data collection system

The collection templates, comprising the following Microsoft Excel Macro-Enabled 2007-2010 workbooks (for which trusts will require Excel 2007 or later to run)

- a main **reference costs workbook** for reporting unit costs and activity, and reconciling these to the final accounts. We refer to this workbook as **REFC**
- a **spells workbook** for reporting spell unit costs and activity. We refer to this workbook as **SPELLS**

We anticipate posting draft copies of the workbooks on Unify2 in December. At this stage, they will include only structure and content, and not functionality or validations

Reference costs system and workbook user guide – a manual to help users submit their data in Unify2

Healthcare Resource Group 4+ (HRG4+) 2013-14 Reference Costs Grouper and documentation[4] - HRG4+ is the currency for a significant part of the reference costs collection. The National Casemix Office[5] at the Health and Social Care Information Centre (HSCIC) publish the Grouper and supporting documentation including user manual, the Code to Group, individual chapter summaries, and a high level summary of changes from the previous costing Grouper release[6]

[3] http://nww.unify2.dh.nhs.uk/Unify2/interface/homepage.aspx
[4] http://www.ic.nhs.uk/casemix/downloads
[5] http://www.ic.nhs.uk/casemix
[6] Following surveys of Grouper documentation which found that, in the main, the NHS were not using the HRG4+ Chapter Listings, the National Casemix Office decided to cease their production from the 2012-13 Reference Costs Grouper onwards. The information held within the Chapter Listings can be found in the Code to Group.

The **Terminology Reference-data Update Distribution (TRUD)** service[7] supply a number of data sets to support consistent coding of activity, including:

- the **chemotherapy regimens list**, including adult and paediatric regimens, with mapping to OPCS-4 codes that have one-to-one relationships with unbundled chemotherapy HRGs
- the National Interim Clinical Imaging Procedure (NICIP) code set of **clinical imaging procedures**[8], with mapping to OPCS-4 codes that relate to unbundled diagnostic imaging HRGs
- the **high cost drugs list** and map to OPCS-4 codes
- the National Laboratory Medicines Catalogue, a national catalogue of **pathology tests**

Patient level information and costing systems and reference costs best practice guide – We are no longer updating this guide. It is in Section 17 of the *Reference costs guidance for 2012-13*[9] for PLICS users wishing to refer to it.

Costing principles and standards

4. For this collection, trusts should have due regard to the costing principles and standards set out in *Approved Costing Guidance*. There are also a number of principles specific to reference costs. These are that reference costs:

(a) are calculated on a full absorption basis to identify the full cost, including redundancy and reorganisation costs, of all services listed in subsequent sections of this guidance

(b) are retrospective, and the quantum of costs used in their production should be reconciled to the audited accounts. Movements in provisions, e.g. for bad debts, redundancy, early retirement, that are reflected in the income and expenditure account should be included in the quantum of costs. The reconciliation statement that forms part of the return is an integral element of the audit trail for this reconciliation

(c) are average unit costs, irrespective of the underlying data supporting their calculation

(d) include the costs of drugs (paragraph 86) or devices (paragraph 85) against the relevant HRGs, even if the drugs or devices are excluded from the national tariff or separately reported as a memorandum item in the reconciliation statement workbook (paragraph 523). The relevant HRG will be an unbundled high cost drug HRG if the drug has a high cost drug OPCS-4 code, otherwise it will be a core HRG or other unbundled HRG

(e) emphasise the cost of delivering the service, and not the location of the service or the funding streams that are used to recover these costs. The services covered are those provided to NHS patients regardless of location under a range of contractual arrangements (e.g. with local authorities for public health services, NHS England for prescribed specialised services, or clinical commissioning groups (CCGs) for other services) where the provider incurs a

[7] http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/home

[8] The NICIP code set is released biannually on 1 April and 1 October each year. Trusts should use the October release that matches the reference costs year, i.e. October 2013 for 2013-14 reference costs.

[9] https://www.gov.uk/government/publications/reference-costs-guidance-for-2012-13

cost.

5. This guidance sets out the requirements for capturing activity to derive unit costs from total costs. As a starting point, we recommend working through the guidance to determine which services the trust provides and how to count activity needed for each service.

6. Include all activity unless we state in Section 13 that it should be excluded. Trusts will be asked to confirm that the activity is an accurate reflection of data reported by the trust in other activity returns such as hospital episode statistics (HES).

Main changes for 2013-14

7. The changes we are making to the reference costs collection in 2013-14 are designed to:

   (a) support the development of price setting, and the development of the scope and design of currencies
   (b) ensure we collect high quality and relevant data
   (c) minimise the administrative burden of national cost collections.

Supporting the development of price setting, and the development of the scope and design of currencies

8. Whilst it will be for Monitor and the NHS England to decide to what extent 2013-14 reference costs are used to set national prices, we are making a number of changes to support the development of price setting, and the development of currencies (for services to which prices could be applied in the future).

9. The **HRG4+ 2013-14 Reference Costs Grouper will include differential spell trim points for elective and non-elective admission methods to mirror the published national prices**, replacing the single spell trim points for both admission methods in previous years. This is designed to make the calculation of national prices more transparent.

10. We are working towards a position where, in future years, trusts will exclude from reference costs the cost, rather than the income, relating to funding streams such as education and training. This reflects the work being done by the Department of Health and Health Education England (HEE) to establish the true cost of delivering clinical placements within secondary care. To support this work, the Department and HEE wrote to all Directors of Finance and costing leads on 7 October 2013, outlining arrangements for **two forthcoming and mandatory cost collections**[10]. The first collection will cover the first six months of 2013-14, and will take place in January 2014. To allow trusts maximum flexibility when making their returns, the submission window will open on 25 November 2013. This will be followed by a full year 2013-14 collection, which will take place around the same time as the reference costs collection.

11. **Neither of these education and training cost collections will have any impact**

[10] Questions about this work should be directed to educationandtraining@dh.gsi.gov.uk

on 2013-14 reference costs:

(a) trusts will report their reference costs net of education and training income as usual
(b) we will ask trusts to estimate their total education and training costs as a memorandum on the reconciliation statement
(c) we may invite a very small number of trusts to resubmit their 2013-14 reference costs net of education and training costs later in 2014.

12. Nationally specified year of care pathway currencies have been mandated for HIV adult outpatients. We are not collecting pathway costs in 2013-14, but we are **collecting attendances against the three groupings for newly diagnosed, stable, and medically complex HIV patients** (paragraph 123).

13. Reference costs have for a number of years included specialist mental health services such as autism spectrum disorder or eating disorders, and a general category for "Other" specialist services. We are removing this "Other" category in 2013-14 and **introducing costing categories**[11] **for the following specialist mental health services** (paragraph 317) covering

(a) mental health services for Deaf children and adolescents
(b) mental health services for military veterans
(c) specialist mental health services for deaf adults
(d) gender identify disorder services.

14. We have also **introduced two additional categories for Children and Adolescent Mental Health Services (CAMHS)**. These are

(a) CAMHS, Admitted Patients, Psychiatric Intensive Care Unit
(b) CAMHS, Community Contacts, Crisis Resolution Home Treatment.

Question 1: Do you provide any other specialist mental health service not currently collected in reference costs?

15. Monitor and NHS England are committed to developing currencies and payment systems for community services. The community tariff working group is considering a number of innovative approaches. We have also met with community trusts who

[11] We use the term "costing category" rather than "currency", which is the unit of healthcare that will be paid for in the national tariff payment system. A good currency is:
- clinically meaningful - that is as a grouping of patients/service users it is accepted by clinicians. Involvement of clinicians in designing the currency packages will help ensure that they are clinically meaningful.
- iso-resource - that is patients within a proposed currency group should require a similar type and amount of resource
- an incentivise to the provision of improved care and mindful of creating perverse incentives
- workable – that is it should be supported by underlying information flows (available or attainable). The cost-benefit of granularity should be considered and data burdens should be kept to the minimum necessary for ease of implementation.

The reference costs collection uses currencies for admitted patient care, outpatient, emergency medicine, adult mental health, ambulance, and some other services. Pending further work on currency development, it uses costing categories for other mental health services and community services that abide, as far as possible, by the above principles. For simplicity, we use the term "currency" in the remainder of this document.

identified improvements that could be made to the reference costs guidance and collection around definitions, currencies, and excluded services. As a result of this consultation, we have made some changes to Section 10, including the **introduction of currencies for wheelchair services, and the introduction or refinement of other costing categories**. These changes are designed to promote costing in community services whilst longer term development work continues. Specifically, we are

(a) **introducing currencies for wheelchair services** covering assessment, equipment, review and repair and maintenance, based on a report commissioned by the Department of Health from Deloitte to develop a tariff for these services
(b) **introducing costing categories for the following allied health professionals:**
  (i) orthotists
  (ii) orthoptists
  (iii) prosthetists
(c) **introducing an "Other Therapists" category** to cover art, drama and music therapists, and complementary or alternative medicine therapists
(d) **splitting the existing single category for podiatrists** into currencies for core podiatry, and specialist and other podiatry
(e) **splitting the existing single category for community dentists** into categories covering
  (i) community dental services
  (ii) general dental services
  (iii) emergency dental services
  (iv) oral health promotion
(f) **updating the categories for health visitors** in line with the Healthy Child Programme
(g) **introducing categories for health promotion drop-in sessions** covering:
  (i) Contraception and sexual health
  (ii) Stop smoking education programme
  (iii) Substance misuse
  (iv) Weight management.

Question 2: Do you have any comments on our proposals for community services in reference costs?

We understand a number of service delivery models apply to orthotic and prosthetic services, with some trusts sub-contracting the service to the independent sector. We would need to take this into account before collecting reference costs for these services.

Question 3: Do you have a service delivery model for orthotic, prosthetic or other community services that we should consider before collecting reference costs for these services?

16. We have made **a number of changes to the audiology section of the guidance** (now included in Section 10 under community services) to:

(a) incorporate new HRGs for hearing assessment
(b) ensure no costs relating to audiology services are excluded from reference costs.

17. We are proposing to align the treatment of **admission avoidance schemes, community rehabilitation teams, and hospital at home and early discharge schemes**, which have been variously treated in previous years, into costing categories for **intermediate care services** (paragraph 400).

Question 4: Do you have any comments on our proposals for intermediate care services?

Collecting high quality and relevant data

18. We are making a small number of **changes to the self-assessment quality checklist** to help improve the usefulness of the information provided (paragraph 67).

19. We are **inviting comment on whether to further differentiate reference costs for adult critical care by all critical care unit functions** (paragraph 185). This change would be designed to support benchmarking of costs.

Question 5: Do you support the further differentiation of adult critical care costs by all critical care unit functions?

20. As noted in last year's guidance, we are asking trusts to **include adult critical care outreach services as an overhead to admitted patient care** (paragraph 195).

21. We are asking trusts to **report community paediatric services under TFC 290 in Section 4 rather than the previously provided currencies in Section 10**.

22. **We have updated the national list of services excluded from reference costs in Section 13, by providing a definition or description for each service, and a reason for its exclusion**. We have also reduced the number of services on the list to support greater clarity and full absorption costing. **Table 2 describes the treatment of services that we have removed from the list,** and states whether costs should be included in 2013-14 submissions against the appropriate currency, or excluded against another line.

Question 6: Do you have any comments on our changes to the national list of services excluded from reference costs?

Table 2: Services removed from Section 13

Service	How should this service be treated in 2013-14?
Admission prevention schemes	Costs and activity should be included against the intermediate care currencies in paragraph 400.
Audiology services (that did not meet the requirements of the audiology section of the guidance in previous years)	Costs and activity should be included against the audiology currencies (paragraph 375).
Bone anchored hearing aids (maintenance and programming)	Costs and activity should be included against the audiology currencies (paragraph 375).
Clinical trials (programmes where clinical treatment related to a condition is monitored and controlled for research purposes)	Costs and activity should be included in the appropriate currencies in this guidance, and research and development income netted off as set out in paragraph 495(c)
Cochlear implants (maintenance and programming)	Costs and activity should be included against the audiology currencies (paragraph 375).
Community veterans mental health pilots	Costs and activity should be included against the currencies for mental health services for military veterans (paragraph 317(f)).

Service	How should this service be treated in 2013-14?
Complementary or alternative medicine	Costs and activity for discrete services provided by such practitioners, e.g. acupuncture or aromatherapy massage should be included under Other Therapists (paragraph 354). Where such practitioners form part of a team providing services such as pain management or orthopaedics, they should be included against the appropriate currency.
Complex or treatment resistant disorders in tertiary settings delivered by mental health trusts	Costs and activity should be included against the appropriate specialist mental health service currencies in paragraph 317.
Discrete external aid and appliance services	Costs should be included in the currencies for orthotists or prosthetists in paragraph 353, or other currencies as appropriate.
Domiciliary visits	Fees payable to consultants for domiciliary consultations[12] should be included against the appropriate currencies as an overhead cost.
Drugs used in assisted reproduction medicine	Costs of drug regimens used for in vitro fertilisation or the high cost gonadotropins used in intra-uterine insemination should be included in the appropriate HRGs for assisted reproduction medicine (MC06Z to MC15Z).
Emergency dental service	Costs and activity should be included in the relevant currency for community dental services in paragraph 362.
Gender identity disorder service	Costs and activity should be included against the appropriate currencies for this service in paragraph 317(d).
GP led open access	Costs and activity should be excluded against primary medical services in Section 13.
GP out of hours services	Costs and activity should be excluded against primary medical services in Section 13.
Independent or charitable hospices	Costs of providing staff or services to independent or charitable hospices should be included against the appropriate currencies in this guidance.
Medical equipment loaned to patients for use in their own homes	Costs should be included as an overhead against the appropriate currencies in this guidance.
Mental health services for Deaf children and adolescents	Costs and activity should be included against the appropriate currencies in paragraph 317(e).
Multi-professional triage teams	Triage costs should be included as an overhead against the appropriate currency (see paragraph 112).
Methadone swallow and depot injection clinics	Costs should be allocated to the appropriate currencies, e.g. drug and alcohol services in paragraph 316.
Needle exchange schemes	Costs should be allocated to the appropriate currencies, e.g. drug and alcohol services in paragraph 316.
Nursing and residential care homes	Costs and activity should be included against the currencies for intermediate care services in paragraph 400, or excluded against NHS continuing healthcare in Section 13.
One stop shops and rapid diagnostic packages[13]	Costs and activity should be included against the appropriate multi-disciplinary or multi-disciplinary outpatient attendances in Section 4.

[12] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/domiciliary_consultation_de.asp?shownav=1

[13] One stop models of care in outpatients are described at

Service	How should this service be treated in 2013-14?
Physically disabled services	Costs and activity should be included against the appropriate currencies (e.g. wheelchair services) or excluded against another appropriate line in Section 13.
Pregnancy advisory service	Costs should be allocated against attendances at sexual and reproductive health clinics in paragraph 136.
Primary dental services	Costs and activity should be allocated to the appropriate community dental service currencies in 362.
Resettlement programmes	Costs should be excluded against another appropriate line in Section 13, e.g. pooled and unified budgets.
School exclusion services	Costs associated with advice given to non-NHS bodies, such as advice to local authorities from community health professionals about excluding children from school, should be excluded against the pooled or unified budgets line in Section 13.
Specialist mental health services for Deaf adults	Costs and activity should be included against the currencies in paragraph 317(e).
Spinal care packages in the community	Costs and activity should be excluded against pooled or unified budgets or another appropriate line in Section 13.
Step down beds in residential facilities	Costs and activity should be included against the currencies for intermediate care services in paragraph 400.
Wheelchair services	Costs and activity should be included against the currencies in paragraph 416.

Minimising the administrative burden of national data collections

23. The Department and its Arms' Length Bodies are signatories to the Concordat for Reducing the Administrative Burden Arising from National Requests for Information. The Concordat commits signatories to core principles governing the collection of data from NHS bodies, and to a collaborative approach and systematic approach to data collections across the health and social care system.

24. In the 2013 reference costs survey trusts reported spending, on average, 93 days collating and submitting the reference costs return. We are conscious of the increasing demands on costing teams as the PLICS collection develops and work continues towards collecting education and training costs separately. We are therefore committed to taking steps to simplify the reference costs collection and minimise the administrative burden.

25. Subject to confirmation from Monitor, we are **removing the distinction between non-elective long and short stays**. Previously, trusts submitted separate unit costs for non-elective long stays (where length of stay is two or more days) and short stays (where length of stay is one day) FCEs. The unit costs were combined for the national tariff calculation, but the separate data were used to inform a short stay emergency adjustment to the national tariff. The purpose of this adjustment is to prevent full payment for a short stay admission in an HRG where a longer length of stay would generally be expected. The reduced rate is related to the average length of stay for the HRG: the higher the average length of stay, the lower the short stay

http://www.improvement.nhs.uk/heart/sustainability/outpatients/one_stop.html

emergency tariff. The adjustment has only been periodically updated and could be performed, if required, using HES or PLICS data.

26. In 2012-13 we piloted a voluntary collection from acute trusts of FCE average unit costs by cost pool group for all admitted patient care HRGs. Following concerns about the data burden, **we are not collecting cost pool data in 2013-14**.

27. We are **removing the following non-mandatory validations**

    (a) **cost relativities that are inconsistent with HRG design** – based on feedback that the number of queries was too challenging and the relativities, upon investigation, proved to be justifiable at the local level
    (b) **same costs reported against different currencies** – based on a recognition that same costs are generally a product of traditional top-down costing processes that trusts will be unlikely to be able to correct during the collection window.

28. We are **introducing materiality thresholds for some of the remaining non-mandatory validations** (paragraph 61).

Question 7: Do you have any comments on our revisions to the non-mandatory validations?

29. We have **merged the reconciliation statement workbook (previously referred to as RECON) with the main reference costs workbook (REFC)**, and **simplified** it by:

    (a) introducing a single reconciliation statement for NHS trusts and NHS foundation trusts
    (b) removing the worksheet which collected information about certain highly specialised services
    (c) removing the memorandum worksheet.

30. Monitor is considering the potential use of the spells data. We therefore anticipate **continuing to mandate the submission of spell costs by all trusts submitting equivalent FCE costs for admitted patient care**. The advice we have received is that it does not present a significant additional burden to submit both.

Scope

31. Subject to the approval of the Review of Central Returns Committee (ROCR)[14], this reference costs collection will be mandatory for all[15] NHS trusts and NHS foundation trusts in existence between 1 April 2013 and 31 March 2014, who should ensure they have the necessary resources and systems to comply fully with the guidance and its timescales.

32. We based our evidence to ROCR on the administrative burden of collating and submitting reference costs on findings from the 2013 reference costs survey. ROCR

[14] http://www.ic.nhs.uk/rocr
[15] With the exceptions of Calderstones Partnership NHS Foundation Trust and NHS Direct, who are not required to submit reference costs.

are also keen to receive feedback on central data collections from colleagues who submit returns, in particular information about the length of time data collections take to complete and any issues, suggested improvements or duplication. Feedback should be submitted to ROCR using an online form[16].

33. Trusts should submit unit costs for all services relating to their own provider function, including services delivered under Any Qualified Provider (AQP), but excluding services listed in Section 13. In line with guidance for provider-to-provider agreements (paragraph 508), the receiving trust should include the costs of services sub-contracted to other trusts.

34. In line with Treasury's *Financial Reporting Manual*, combining two or more public bodies or transferring functions from one part of the public sector is accounted for using absorption rather than merger accounting. Thus:

    (a) where trust A is dissolved in-year, e.g. on 30 June 2013, and is acquired in-year by trust B, e.g. on 1 July 2013, it is the responsibility of trust B to ensure a single 2013-14 reference costs return combining the costs and activity of both trust A and B is submitted by the mandatory deadline. When completing the reconciliation statement, trust B will need to reconcile to the sum of two sets of accounts: one covering trust A from 1 April 2013 to 30 June 2013, and one covering trust B from 1 April 2013 to 30 June 2013 and trust A and B combined from 1 July 2013 to 31 March 2014
    (b) where trust C is dissolved on 31 March 2014 and is acquired by trust D on 1 April 2014, a separate reference costs return will be required for each trust, although responsibility for the completion of both returns by the mandatory deadline will fall to trust D
    (c) where there is a transfer of function from trust E to trust F and neither trust dissolves, each trust will account for the transferred function for the period they provided the service. Reference costs will follow the financial accounts and no adjustment will be required. A complication with absorption accounting is that any assets transferred between the bodies could results in a gain or loss in the Statement of Comprehensive Income. Any such gain or loss should not be included when calculating reference costs and is not included in the reconciliation statement.

35. It may be necessary to speak to financial accounts colleagues about any such transfers within the organisation.

36. Successful applicants to NHS foundation trust status during the financial year must submit one full year's reference costs for the sum of the NHS trust and the NHS foundation trust.

37. Where a spell begins in the preceding reference costs year and continues into the current reference costs year, all associated FCEs should be included. Where a spell begins in the current reference costs year and continues into the next reference costs year all associated FCEs should be excluded.

[16] http://www.ic.nhs.uk/article/1798/ROCR-approved-data-collections

Timetable

38. Table 3 gives a provisional high level timetable for 2013-14 reference costs.

Table 3: Provisional timetable

Date	Milestone
22 November 2013	Department publishes *Draft reference costs guidance for 2013-14* for NHS feedback
December 2013	Department releases draft reference cost workbooks on Unify2
13 December 2013	Deadline for NHS feedback on *Draft reference costs guidance for 2013-14*
February 2014	Monitor publishes *Approved Costing Guidance* Department publishes *Reference costs guidance for 2013-14* HFMA publishes *Clinical Costing Standards for 2014-15*
27 March 2014	Release of HRG4+ 2013-14 Reference Costs Grouper and documentation
March 2014	Release of Unify2 compliant test workbooks
April 2014	Release of Unify2 compliant final workbooks
30 June 2014	Reference costs collection window opens
25 July 2014	Reference costs collection window closes
September 2014	Release of draft RCIs on Unify2
October 2014	Publication of national schedules of reference costs, final RCIs and source data

39. Table 4 describes the collection window in more detail.

Table 4: Collection window

Date	Milestone	Notes
30 June 2014	Collection window opens	Finance Directors that are ready to sign off REFC and SPELLS may do so at any date from this date.
11 July 2014	Deadline for initial REFC submissions	Experience from previous years suggests that trusts that wait until the third week before making an initial submission face the biggest challenge in terms of timeliness and accuracy. **Trusts must make an initial submission of REFC by this deadline.**
14 July 2014	Deadline for Finance Directors to sign off REFC. Only Finance Directors will have Unify2 accounts with sign off rights. Finance Directors unable to sign off on their designated date should contact us to agree an alternative date, or to agree a named deputy who will be granted a temporary Unify2 account with sign off rights. Unless there are exceptional circumstances, any request for an alternative date will be allocated an earlier date.	Trusts A - D[17]
15 July 2014		Trusts E - M
16 July 2014		Trusts N - S
17 July 2014		Trusts T - Z
21 July 2014	Deadline for Finance Directors to sign off SPELLS.	Trusts A - D
22 July 2014		Trusts E - M
23 July 2014		Trusts N - S
24 July 2014		Trusts T - Z
25 July 2014	Collection window closes.	**There will be no opportunity to resubmit after this date.**

[17] See Annex A

NHS Data Model and Dictionary

40. Where possible, we have aligned the requirements of the reference cost collection with the definitions in the NHS Data Model and Dictionary[18] (the Data Dictionary) and included links in this guidance.

Treatment function codes

41. Admitted patient care, outpatient, and some unbundled services should be reported by treatment function[19]. The Information Standards Board (ISB) issued the latest changes to treatment function codes (TFCs) in Amd 17/2012[20] in November 2012. These changes have been incorporated into the list of TFCs[21] in the Data Dictionary, but trusts should note they are only available to flow in the latest version of the commissioning data sets (CDS 6.2)[22]. All these TFCs will be available in the reference costs workbook, except those listed in Table 5. A few trusts have opted to report all admitted patient care and outpatient activity using reference costs pseudo code 999. However, trusts should where possible report against the relevant TFC.

Table 5: TFCs excluded from the reference costs workbook

TFC	Description	Rationale	Para
264	Paediatric cystic fibrosis	Costs and activity should be reported against cystic fibrosis year of care currencies	449
343	Adult cystic fibrosis service	Costs and activity should be reported against cystic fibrosis year of care currencies	449
424	Well babies	Costs and activity should be reported under obstetrics (501) or midwife episodes (560), and activity excluded	469
700	Learning disability	Learning disability services are excluded from reference costs	469

42. Table 6 lists codes for activity not covered by TFCs.

Table 6: Codes for activity not covered by TFCs

Code	Description
999	Global trust codes
CMDT_B	Breast cancer MDT meetings
CMDT_C	Colorectal cancer MDT meetings
CMDT_LG	Local gynaecological cancer MDT meetings
CMDT_SpG	Specialist gynaecological cancer MDT meetings
CMDT_SpU	Specialist upper gastrointestinal cancer MDT meetings
CMDT_Oth	Other cancer MDT meetings
DAPF	Direct access plain film
FPC	Sexual and reproductive health clinic (formerly family planning clinic) attendances
HIV1	HIV or AIDS, category 1, new patients

[18] http://www.datadictionary.nhs.uk/
[19] http://www.datadictionary.nhs.uk/data_dictionary/classes/t/treatment_function_de.asp?shownav=1
[20] http://www.isb.nhs.uk/documents/isb-0028/amd-17-2012/index_html
[21] http://www.datadictionary.nhs.uk/web_site_content/supporting_information/main_specialty_and_treatment_function_codes.asp?shownav=1
[22] http://www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/cds_version_6-2_type_list.asp?shownav=1

Code	Description
HIV2	HIV or AIDS, category 2, stable patients
HIV3	HIV or AIDS, category 3, medically complex patients

Healthcare resource groups

43. HRGs underpin the national tariff from costing through to payment. They are refined every year in line with changing clinical practice and policy requirements. Reference costs for admitted patient care, outpatients, emergency medicine and unbundled services are collected using the latest version, HRG4+.

44. Trusts must use outputs from the HRG4+ 2013-14 Reference Costs Grouper (the Grouper), and the suite of supporting documentation, which will be released on 28 March 2014, when compiling their reference costs.

45. The Grouper will be supported by the underlying primary classification systems and requires inputs from the CDS covering admitted patient care, critical care, outpatients and emergency medicine. The renal dialysis core HRGs for chronic kidney disease are generated by use of fields from the National Renal Dataset rather than from a CDS (paragraph 255).

46. Unbundled HRGs (Section 5) are a key design feature in HRG4+. This guidance explains where costs and activity should be reported against unbundled HRGs, and where they should be reported against core HRGs.

47. Table 7 lists HRGs where zero costs should be allocated. We will exclude these HRGs from the workbooks.

Table 7: Zero cost HRGs

HRG	Description	Rationale
PB03Z	Healthy Baby	Costs should be reported as part of the maternity delivery episode
DZ13A	Cystic fibrosis with complications and comorbidities (CC) Score 1+	Costs should be reported against cystic fibrosis year of care currencies
DZ13B	Cystic fibrosis without CC Score 0	
PD13C	Cystic fibrosis with length of stay 0 days	
PD13D	Cystic fibrosis with length of stay between 1 and 7 days	
PD13E	Cystic fibrosis with length of stay between 8 and 14 days	
PD13F	Cystic fibrosis with length of stay 15 days or more	
LA97A	Same Day Dialysis Admission or Attendance, 19 years and over	Costs should be reported against the LD HRGs
LA97B	Same Day Dialysis Admission or Attendance, 18 years and under	

48. The National Service Framework for children defines a child as up to and including 18 years of age and an adult as 19 years and over. These definitions of a child and adult are generally applied within HRG4+ and to other services in reference costs, except where specified, e.g. cystic fibrosis.

Primary classifications

49. HRG4+ relies on two underlying primary classification systems:

    (a) the International Statistical Classification of Diseases and Related Health

Problems Tenth Revision (ICD-10)
(b) the OPCS Classification of Interventions and Procedures (OPCS-4).

50. The NHS should have implemented:

(a) ICD-10 4th Edition on 1 April 2012, as notified in ISB 0021[23]. The NHS Classifications Service have provided updated data files and training materials[24] for the NHS and system suppliers
(b) OPCS-4.6[25] [26], released on 1 April 2011.

51. These revisions underpin HRGs in the HRG4+ 2013-14 Reference Costs Grouper.

Queries

52. A number of national costing groups oversee the development of costing in areas such as mental health and ambulance services. Local costing groups provide an opportunity for providers to share best practice.

53. The Unify2 forum is an informal forum for NHS costing colleagues. We also use it to post other relevant materials in the lead up to the collection window.

54. Queries about HRGs and the HRG4+ 2013-14 Reference Costs Grouper should be directed to enquiries@ic.nhs.uk, and queries about clinical coding and the Data Dictionary to datastandards@nhs.net.

55. For queries requiring an official response:

(a) NHS trusts with queries that cannot be resolved using these resources should contact the NHS Trust Development Authority (NHS TDA) at TDA.PBRqueries@nhs.net in the first instance
(b) NHS foundation trusts should contact us directly at pbrdatacollection@dh.gsi.gov.uk.

[23] http://www.isb.nhs.uk/library/standard/119
[24] http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/icd10/icd10updates/index_html
[25] http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4
[26] OPCS-4.7 is due to be implemented on 1 April 2014 and will underpin future Groupers.

Section 2: Data quality, validation and assurance

Introduction

56. This section describes:

    (a) the validations that will be performed on the cost data during the collection window to help improve quality
    (b) the self-assessment quality checklist that must be completed alongside reference cost returns
    (c) the requirement for Boards to approve the costing process and Finance Directors to sign off the cost data.

57. Accurate cost data is fundamentally important to support the joint responsibility of Monitor and NHS England for pricing NHS services in England. Monitor has stated its long-term aspiration to move to a pricing system based on PLICS data, but this will take time to implement. In the meantime, these 2013-14 reference costs may be used to inform the 2016-17 national tariff.

58. NHS providers and commissioners use the data for reporting to executive teams, benchmarking, contract negotiations and local pricing of non-tariff areas.

59. Reference costs support the Department's commitment to improving data transparency and making information available to the public as set out in its business plan for 2013 to 2015[27]

60. They are also used by the Department, Monitor, NHS England, NHS TDA, HSCIC, and other organisations and individuals to:

    (a) hold the Department and its ministers to account for the use of NHS resources in replies to parliamentary questions, freedom of information requests and other official correspondence
    (b) support implementation of the EU cross border healthcare directive, which requires transparent and objective mechanisms for the reimbursement of patient costs between member states
    (c) inform the weighted capitation formula used to allocate resources to NHS commissioners
    (d) provide comparative costs to support evaluation of new or innovative medical technologies and interventions
    (e) inform estimates of NHS productivity
    (f) inform the design of HRGs and other currencies.

[27] https://www.gov.uk/government/publications/department-of-health-business-plan-2013-to-2015

Mandatory validations

61. Our mandatory validations are designed to assure the basic integrity of the data. All validations are embedded within the relevant workbooks unless stated otherwise. Trusts will not be able to sign off their returns until their data passes each of these validations.

Table 8: Mandatory validations

Validation	Description	Workbook	Worksheet
Activity > 0	Activity must be positive	Both	All
Activity = integer	Activity must be an integer	Both	All
Activity and unit cost	If activity is reported, then a unit cost must be reported, and vice versa	Both	All
Bed days > = FCEs	Number of inlier bed days must be greater than or equal to FCEs	Both	APC
Duplicate entry	Each combination of department code, service code and currency code must be unique	REFC	All
Excess bed day costs without excess bed day activity	If excess bed day costs are reported, then excess bed day activity must be reported, or vice versa	REFC	APC
Excess bed days without inlier activity	If excess bed day costs are reported, inlier activity must be reported	Both	APC
HRG code invalid	HRG codes must match those provided in the HRG4+ 2013-14 Reference Costs Grouper	REFC	Flexible worksheets
Inlier bed days < HRG trim point * no. of FCEs	Inlier bed days must be less than the HRG trim point multiplied by number of FCEs	Both	APC
Missing entry	Missing values (excluding cost or activity) within a row of data	REFC	All
No data	Codes have been supplied, but no unit costs or activity	REFC	Flexible worksheets
Department code invalid	Department code must be valid code, e.g. DC, EI etc	REFC	Flexible worksheets
TFC code invalid	TFC codes must match those in the Data Dictionary	REFC	Flexible worksheets
Unit cost >= 20	Unit cost must be positive and greater than or equal to £20.00	Both	APC
Unit cost >= 5	Unit cost must be positive and greater than or equal to £5.00	REFC	OP, UB, DIAGIM
Unit cost >= 0.01	Unit cost must be positive and greater than or equal to £0.01	REFC	All worksheets except APC, OP, UB and DIAGIM
Unit cost = #.##	Unit cost must be to two decimal places	REFC	All
SPELLS vs REFC	Total spell costs must reconcile to within +/- 0.1% of total FCE inlier and excess bed day costs by each admission type (day case, ordinary elective, and ordinary non-elective)	Both	N/A

Non-mandatory validations

62. Our non-mandatory validations are designed to improve the quality and accuracy of the data. In addition to building these into the workbooks, we will post regular feedback on the Unify2 forum during the collection window.

63. A non-mandatory validation is not in itself an indication that the data are incorrect, and there are many valid reasons why data may not pass a non-mandatory validation, for example a small number of high cost episodes may result in an

average unit cost greater than £50,000. Nevertheless, it is a requirement for trusts to consider these validations and make any necessary revisions, confirming the extent to which they have done so on the self-assessment quality checklist. In response to feedback that the volume of queries generated by non-mandatory validations was challenging in 2012-13, we have dropped some validations and introduced materiality thresholds for others. Table 9 gives full details.

Table 9: Non-mandatory validations that require investigation

Validation	REFC/ SPELLS	Worksheets	Materiality threshold	Exceptions
Costs that do not cover the costs of a high cost device HRGs where the activity should always include a high cost device, and the reported cost is less than an expected minimum cost for that device.	Both	APC, OP	None	None
Day case unit costs more than ordinary elective unit costs HRGs (in the same TFC in REFC) where the day case unit cost is more than double the ordinary elective unit cost.	Both	APC	10 FCEs or spells	None
Follow up outpatient attendance unit costs greater than first unit costs Follow up unit costs (HRGs in WF01*) that are more than double the first unit cost (HRGs in WF02*) for the same outpatient attendance in the same TFC.	REFC	OP	10 attendances	None
Market share of cost and activity Market share of a service (defined as the combination of department and HRG sub-chapter for acute services, or department, service and currency for non-acute services) varies by 25% or more between cost and activity, e.g. market share of cost is 25% and market share of activity is 50%	Both	All	None	None
Mental health care cluster and admitted patient care Cluster days are not expected to be reported in an admitted patient care setting, for mental health care clusters 01, 02 and 03.	REFC	MHCC	None	None
Outliers Costs that are less than one-tenth or more than 10 times of the national mean unit cost. The workbooks will use 2012-13 means. During the collection window, we recommend that organisations refer to the verification report in Unify2, which is updated overnight and shows real time means. The feedback we post on the Unify2 forum during the collection will be based on real time 2012-13 means.	Both	All	None	None

Validation	REFC/ SPELLS	Worksheets	Materiality threshold	Exceptions
Unit costs over £50,000	Both	All	None	HRGs which have 2012-13 national average mean unit costs greater than £50,000 are excluded
Unit costs under £5	REFC	All	None	The following services are excluded: • Ambulance service calls • Direct access pathology • Mental health care clusters
Variance between reference cost years is greater than 25% Variance between 2012-13 and 2013-14 total costs or total activity is greater than 25%. The workbook analysis will be at worksheet level. The Unify2 forum feedback will be by department and HRG for acute services, and department, service and currency for non-acute services	REFC	All	25%	None
FCE to spell ratio deviates significantly from the national average ratio FCE to spell ratio by HRG is less than 1.00 or greater than 1.80	SPELLS	All	None	None

Resubmissions of data

64. Once the collection has closed, trusts will not be allowed to resubmit data via Unify2.

65. During the analysis of submissions during August and September, the reference costs team will contact trusts if analysis suggests there may be an error in their data. Trusts will be required to investigate their submission further and report back on any errors found. An impact analysis will be performed by the reference costs team between the original submitted data and the corrected data. Only where a trust has errors in their data that would materially affect national average unit costs will a resubmission via Unify2 be authorised.

66. Trusts with data errors which do not have a material impact on national average unit cost but which impact on their RCI will have their RCI annotated in the publication, so users of the data are aware, if for example they are making comparisons between trusts.

Self-assessment quality checklist

67. The onus on the production of sound, accurate and timely data that is right first time rests with each NHS organisation.

68. The self-assessment quality checklist in Table 10 must be completed by all trusts.

Table 10: Self-assessment quality checklist

Check	Response
Total costs: The reference costs quantum has been fully reconciled to the signed annual accounts through completion of the reconciliation statement workbook in line with guidance	○ Fully reconciled to within +/- 1% of the signed annual accounts ○ Fully reconciled to within +/- 1% of the draft annual accounts [state reason]
Total activity: The activity information used in the reference costs submission to report admitted patient care, outpatient attendances and A&E attendances has been fully reconciled to provisional Hospital Episode Statistics and documented	○ Fully reconciled and documented ○ Partly reconciled ○ n/a – reconciliation completed but to another source [state reason] ○ Not reconciled
Sense check: All relevant unit costs[28] under £5 have been reviewed and are justifiable	○ All relevant unit costs under £5 reviewed and justified [state reason] ○ n/a – no relevant unit costs under £5 within the submission
Sense check: All relevant unit costs[29] over £50,000 have been reviewed and are justified	○ All relevant unit costs over £50,000 reviewed and justified [state reason] ○ n/a – no relevant unit costs over £50,000 within the submission
Sense check: All unit cost outliers (defined as unit costs less than one-tenth or more than ten times the previous year's national mean average unit cost) have been reviewed and are justifiable	○ All unit cost outliers reviewed and justified [state reason] ○ n/a – no unit cost outliers within the submission
Benchmarking: Data has been benchmarked where possible against national data for individual unit costs and for activity volumes (the previous year's information is available in the Audit Commission's National Benchmarker[30])	○ All cost and activity data within the submission has been benchmarked using the Audit Commission's National Benchmarker prior to submission ○ All cost and activity data within the submission has been benchmarked using another benchmarking process [state] ○ Some but not all cost and activity data within the submission has been benchmarked using the Audit Commission's National Benchmarker prior to submission ○ Some but not all cost an activity data within the submission has been benchmarked using another benchmarking process [state] ○ No benchmarking performed on the cost data prior to submission
Data quality: Assurance is obtained over the quality of data for 2013-14	○ An external audit has been performed on data quality for 2013-14 ○ An internal audit has been performed on data quality for 2013-14 ○ Internal management checks have provided assurance over data quality for 2013-14 ○ Assurance has been obtained over data quality but not for 2013-14 ○ No assurance has been obtained over data quality

[28] Exceptions are listed in Table 9.
[29] Exceptions are listed in Table 9.
[30] http://www.audit-commission.gov.uk/health/audit/paymentbyresults/benchmarkerandportal/Pages/default.aspx

Check	Response
Data quality: Assurance is obtained over the reliability of costing and information systems for 2013-14	o An external audit has been performed on costing and information system reliability for 2013-14 o An internal audit has been performed on costing and information system reliability for 2013-14 o Internal management checks have provided assurance over costing and information system reliability for 2013-14 o Assurance has been obtained over costing and information system reliability but not for 2013-14 o No assurance has been obtained over costing and information system reliability
Data quality: Where issues have been identified in the work performed on the 2013-14 data and systems, these issues have been resolved to mitigate the risk of inaccuracy in the 2013-14 reference costs submission	o All exceptions have been resolved and the risk of inaccuracy in the 2013-14 reference costs submission fully mitigated o Some exceptions have been resolved but not all o Exceptions have all been resolved going forward but there is an historical risk to the accuracy of the 2013-14 reference costs submission due to resolution being during 2013-14 and not being applied retrospectively o Exceptions have yet to be resolved o n/a – no exceptions noted
Data quality: All other non-mandatory validations as specified in the guidance and workbooks have been considered and any necessary revisions made	o All non-mandatory validations have been considered and necessary revisions made o All non-mandatory validations have been considered and some but not all necessary revisions have been made [specify and state reason] o Some non-mandatory validations have been considered and necessary revisions made [specify and state reason] o No non-mandatory validations have been investigated [state reason] o n/a – no non-mandatory validations have occurred

Board approval and Finance Director sign off

69. The Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee, is required to confirm in advance of the reference costs submission (for example at the April or May Board meeting) that it is satisfied with the trust's costing processes and systems, and that the trust will submit its reference cost return in accordance with guidance. In providing this confirmation, Boards or their appropriate sub-committees may wish to satisfy themselves that procedures are in place to ensure that the self-assessment quality checklist can be completed at the time of the reference cost submission. Trusts that are unable to provide this confirmation should provide details of non-compliance. Specifically, Boards or their appropriate sub-committees are required to confirm that:

    (a) costs will be prepared with due regard to the principles and standards set out in Monitor's *Approved Costing Guidance*
    (b) appropriate costing and information capture systems are in operation
    (c) costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance
    (d) procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return.

70. The Finance Director is required to sign off the reference costs return in Unify2, confirming that:

    (a) the Board or its appropriate sub-committee has approved the costing process ahead of the collection
    (b) the return has been reconciled internally and is an accurate reflection of cost and activity terms of the services provided
    (c) finance teams have actively engaged clinicians and other relevant non-finance stakeholders in the costing process
    (d) the self-assessment quality checklist has been completed and used to improve quality and to provide assurance to the Department about the accuracy of the return.

External assurance

71. Some trusts will be subject to external review as part of a wider external assurance programme.

Section 3: Admitted patient care

Introduction

72. This section covers the following types of admitted patient care:

 (a) day case electives[31]
 (b) ordinary electives[32] [33]
 (c) ordinary non-electives[34]
 (d) regular day or night admissions[35].

73. Trusts must submit their admitted patient care costs by FCE, TFC and HRG. It is for trusts to decide which TFC to use for a given service.

74. Trusts must also submit, in a separate spells workbook, their admitted patient care costs (excluding regular day or night admissions) by spell and HRG.

75. The HRG4+ 2013-14 Reference Costs Grouper will attach a core HRG to every FCE or spell. Trusts will only report core HRGs here. Trusts will report unbundled HRGs separately (Section 5).

FCE costs

76. The following paragraphs cover issues that affect the regular collection of FCE costs and, unless otherwise indicated, spell costs.

Ordinary non-electives

77. The separate identification of ordinary non-electives as either short stay (length of stay equal to 1 day) or long stay (length of stay 2 or more days) is no longer required from 2013-14.

78. Note that the Grouper automatically adds one day to any ordinary admission with a zero length of stay, so length of stay will always be at least 1.

Excess bed days and trim points

79. Excess bed day costs must be reported separately for ordinary elective and ordinary

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[31] http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1

[32] http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1

[33] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/e/elective_admission_de.asp?shownav=1

[34] All national codes excluding 11, 12 and 13 at http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1

[35] http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1

non-elective FCEs but not for spells. Spell unit costs should be untrimmed.

80. The cost per day for excess bed days should generally include only the costs associated with the time based ward cost pool group, and any associated variable costs such as low intensity nursing, blood tests, drugs, dressings, or therapies. We would expect that care of patients is less intensive than at the beginning of the FCE and that costs would be less per day than for the truncated HRG, although we recognise that active treatment does sometimes continue beyond the trim point especially for specialised services.

81. Given that the costs may vary by admission method, costs and activity for excess bed days should be reported separately for ordinary elective and non-elective FCEs. The Grouper output will split these between ordinary electives and non-electives as a matter of course. Excess bed days need to be calculated, as a minimum, on the basis of their total cost divided by their number.

82. Trusts should use the trim points included in the HRG4+ 2013-14 Reference Costs Grouper and supporting documentation to calculate HRG length of stay and associated excess bed days.

83. Some HRGs have a trim point of 32,000. This is due to insufficient data available to calculate valid trim points or where maximum length of stay logic is included in the HRG4+ design.

Regular day or night admissions

84. Regular day or night admissions[36] are reported in the FCE collection but not the spells collection. Admissions for specialist care such as cystic fibrosis, radiotherapy, or renal dialysis should be reported against the relevant sections of the collection, and not here.

Devices

85. Costs and activity relating to all devices, even if currently excluded from national prices, should be included against the HRG to which they relate. To inform price setting, the number and total cost of the devices listed in Table 11, and the number of patients to which they were fitted, should also be reported in the drugs and devices worksheet.

Table 11: Devices requiring memorandum costs

Device
3 dimensional mapping and linear ablation catheters used for complex cardiac ablation procedures
Aneurysm coils and flow diverters for intracranial aneurysms
Bespoke orthopaedic prostheses (Bespoke prostheses designed and manufactured for individual patients plus modular limb salvage replacements for femur or shoulder (non CE marked))
Biological mesh
Bone anchored hearing aids (BAHA)
Bone growth stimulators
Circular external fixator frame

36 http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1

Device
Cochlear implants
Consumables associated with per oral single operator cholangioscope
Consumables for robotic surgery
Devices used in connection with pulmonary artery banding
Drug-eluting peripheral angioplasty balloon
ICD with cardiac resynchronisation therapy (CRT) capability (Bi-ventricular (three leads))
Implantable cardioverter-defibrilator (ICD) (Single or dual chamber (one or two leads))
Insulin pumps and pump consumables
Intracranial stents
Intrathecal drug delivery pumps
Pacemaker extraction sheaths
Maxillofacial bespoke prostheses
Neurostimulation devices: deep brain
Neurostimulation devices: occipital nerve
Neurostimulation devices: sacral
Neurostimulation devices: spinal cord
Neurostimulation devices: vagal
Occluder, vascular, appendage and septal devices
Percutaneous valve repair and replacement devices for mitral and pulmonary valve only
Percutaneous valve replacement devices for TAVI
Radiofrequency, cryotherapy and microwave ablation probes and catheters (When used for treating tumours)
Stents: carotid, iliac and renal stents (Includes embolic protection devices)
Stents: endovascular stent graft (Includes aortic stent grafts)
Stents: peripheral vascular stents (Includes peripheral vascular drug eluting stents)
Ventricular assist devices (VAD) and prosthetic hearts

Drugs

86. The high cost drug OPCS codes, and therefore the unbundled high cost drug HRGs (paragraph 212), do not capture all high cost drugs. Others are included in core HRGs. To inform price setting, the costs of the drugs in Table 12 should be reported in the relevant unbundled or core HRG (except cystic fibrosis drugs which should be excluded from the year of care currencies for cystic fibrosis (paragraph 466)). They should also be reported in the drugs and devices worksheet, except when used in chemotherapy to treat neoplasms.

Table 12: Drugs requiring memorandum costs

Drug name
Alisporivir
Aztreonam Lysine (when delivered via nebulisation/inhalation)*
Cinacalcet
Cobicistat
Colistimethate sodium (when delivered via nebulisation/inhalation)*
Collagenase
Conestat alfa
Darbopoetin alfa
Dimethyl fumarate
Dolutegravir

Drug name
Dornase alfa (when delivered via nebulisation/inhalation)*
Elvitegravir
Elvitegravir with Cobicistat, Emtricitabine and Tenofovir
Epoetin alfa
Epoetin beta
Epoetin zeta
Faldaprevir
Gammanorm
Hizentra
Ivacaftor
Lanthanum
Laquinimod
Mannitol*
Pazopanib
Sevelamer
Simeprevir
Teriflunomide
Tobramycin (when delivered via nebulisation/inhalation)*
Treprostinil sodium
Turoctocog alfa

* these drugs should be reported separately for cystic fibrosis (by the currency bandings 1 to 5) and for other care

Obstetrics and maternity admitted patient episodes

87. There are no plans to collect pathway cost for maternity in 2013-14.

88. All obstetrics and maternity admitted patient episodes should be reported under obstetrics (TFC 501) or midwife episodes (TFC 560) and, in line with Data Dictionary guidance on admission method[37], as non-elective.

89. All activity relating to HRG PB03Z (healthy baby) or TFC 424 (well babies) should be excluded. Associated costs should be reported as part of the total costs of the maternity delivery episode against the relevant HRG. Note that the Data Dictionary defines TFC 424 as “care given by the mother or substitute with medical and neonatal nursing advice if needed”. TFCs describe the carer, in this case the mother or substitute. We would expect trusts to use the TFC of the appropriate care professional (obstetrician, paediatrician or consultant midwife) rather than TFC 424 for babies with a minor or major diagnosis (HRGs PB01Z or PB02Z) or receiving a procedure driven HRG.

90. Babies who are unwell (i.e. any babies that are not defined as well babies, e.g. neonatal level of care 1, 2 or 3) will generate their own admission record. Costs should be reported against the relevant HRG and, where applicable, the unbundled neonatal critical care HRGs.

91. The Grouper includes HRGs that cover ante-natal and post-natal care, scans and

[37] http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1

other procedures that occur outside the delivery episode. Providers should take care to differentiate accurately and consistently between the costs of this activity.

92. HRGs NZ30* to NZ51* cover delivery episodes, and are designed to reflect the costs associated with different types of delivery.

93. Maternity outpatients, scans, screens and tests are covered in paragraph 130. Community midwifery is covered in paragraph 361.

Renal transplantation

94. Guidance on submitting costs against the adult renal transplantation HRG currencies is in Annex B.

Spell costs

95. Until 2011-12, reference costs had only been reported by FCE, whilst national prices for admitted patient care have always been spell based. The conversion of FCE costs into spell costs is complicated, and the collection of spell costs may be used to support a more transparent calculation of national prices.

96. A hospital provider spell[38] is defined as the period of admission to discharge or death for the same patient at the same provider. Where a patient has multiple distinct admissions on the same day (e.g. a planned day case in the morning, discharged, re-admitted in the afternoon for a second day case and then discharged) then each of these admissions should be counted separately. To be consistent with the FCE collection, only spells ending in 2013-14 should be included (paragraph 37).

97. Spells data will be submitted in a separate workbook by all trusts that submit equivalent FCE costs as follows:

   (a) by admission method (day case, ordinary elective, ordinary non-elective)
   (b) number of spells by HRG. Spells should be assigned based on the SpellReportFlag field in the Grouper. Unlike FCEs, there is no requirement to differentiate spells by TFC
   (c) average unit cost per spell by HRG, untrimmed for any excess bed days
   (d) number of spell inlier bed days by HRG
   (e) number of spell excess bed days by HRG (using the trim points differentiated by admission method referred to in paragraph 9).

98. Except where stated above, the submission of spell costs and activity should be on the same basis as the submission of FCE costs and activity. Each spell cost should be the sum of the inlier and excess bed day costs of each of its constituent FCEs. Ideally, spell costs should be built from patient level costs. Where this is not possible, providers should use FCE average unit costs to construct spell costs.

[38] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/h/hospital_provider_spell_de.asp?shownav=1

Section 4: Outpatient services

Introduction

99. This section covers:

    (a) outpatient attendances, including ward attendances
    (b) procedure driven HRGs in outpatients.

100. Outpatient attendances and procedures should be reported by HRG and TFC currencies. Where a procedure is reported in outpatients, an outpatient attendance cannot also be counted for the same activity. The Grouper may attach one or more unbundled HRGs to the core HRG produced. Only core HRGs should be reported within this section. Unbundled HRGs should be reported separately (Section 5).

101. The costs of investigations, tests, drugs, devices or other care that do not generate a separate HRG should be included at the point of commitment, up to the point where the patient accesses another service that is separately identified in another area of the reference costs collection.

102. For example, some trusts might provide blood tests as part of a first outpatient attendance. In other trusts, patients might return for blood tests at their convenience or on an appointment basis, prior to a follow up outpatient appointment. In both circumstances, the costs of these tests should be reported as part of the first outpatient attendance only, as they are generally completed prior to a subsequent follow up outpatient attendance and do not generate a separate HRG. But a patient returning for a colonoscopy in outpatients, for example, would generate a separate HRG and these costs would not be included at the point of commitment.

Outpatient attendances

103. Outpatient attendances[39] in HRG4+ (WF01* and WF02*), generated from a number of mandated fields in the outpatient CDS, are organised by:

    (a) first and follow up attendance
    (b) face to face and non face to face attendance
    (c) single and multi-professional attendance.

104. Where a patient sees a healthcare professional in an outpatient clinic setting and receives healthcare treatment, this can be counted as valid outpatient activity. NHS providers offer outpatient clinics in a variety of settings and should be included in reference costs where operated by the provider within a contract. This includes clinics outside main hospital sites in premises not owned by the NHS provider, such as GP practice premises.

105. Outpatient clinics held by a clinician or nurse whilst acting in a private capacity, and which are not part of the trust's income stream, are excluded from reference costs.

[39] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/o/out-patient_attendance_consultant_de.asp?shownav=1

The same rules apply to outpatient clinics held by a clinician or other primary care practitioner as part of any primary medical services contract.

106. Reference costs do not distinguish between attendances that are pre-booked or not. A different consultant other than the one a patient was admitted under seeing that patient (e.g. for psychiatric assessment of a medical patient), should be reported here as a consultant led outpatient attendance. A patient attending a ward for examination or care will be counted as an outpatient attendance if seen by a doctor. If seen by a nurse, they are a ward attendance[40]. No designated worksheet exists for ward attendances, costs and activity for which should be reported here as non consultant led outpatient attendances under the appropriate TFC.

First and follow up

107. First attendances[41] are defined in the Data Dictionary. Follow up attendances are those that follow the first attendance irrespective of whether it happened in a previous financial year. Single professionals seeing a patient sequentially as part of the same clinic should be reported as two separate attendances (a first and a follow-up if professionals are in the same team, or two firsts if they are in a different team).

Face to face and non face to face

108. Non face to face contacts[42] should only be included in the collection where there is an opportunity for discussion between patient and healthcare professional. A telephone call to explain the ramifications of test results to a patient would be included, but a telephone call, text or e-mail solely to inform patients of results are excluded.

109. Both face to face and non face to face activity is only valid if it directly entails contact with the patient or with a proxy for the patient, such as the parent of a young child. Contacts with proxies only count if the contact is in lieu of contact with the patient, and the proxy is able to ensure more effectively than the patient that the specified treatment is followed. This is most likely to be the case where the patient is unable to communicate effectively, say for an infant, or for a person who is mentally ill or has learning disabilities.

110. Contacts about the patient, either face to face or non face to face, cannot be counted as valid activity in any service reported in reference costs, with the single exception of cancer multi-disciplinary teams as discussed in paragraph 139. Where organisations are unable to distinguish between face to face and non-face to face activity, all costs for a particular TFC should be reported as face to face activity only.

111. As a general principle, the same patient can access a service as a face to face and

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40 http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/w/ward_attendance_de.asp?shownav=1

41 http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/f/first_attendance_de.asp?query=First%20Attendance&rank=100&shownav=1

42 http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1

non face to face contact in the same financial year. A single patient can therefore appear in both categories accessing the same service in two different ways. There is no requirement that stipulates that only those patients that have had a face to face contact can be counted as having subsequent non face to face contacts.

112. There are no plans to allow the reporting of triage services as activity rather than an overhead in reference costs.

Single and multi-professional

113. The generation of one of the multi-professional HRGs depends on the recording of OPCS codes in the patient record that denote a multi-professional or multi-disciplinary attendance.

114. Multi-professional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time.

115. Multi-disciplinary attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time when two or more of the care professionals are consultants from different national main specialties.

116. These definitions apply when a patient benefits in terms of care and convenience from accessing the expertise of two or more healthcare professionals at the same time. The clinical input of multi-professional or multi-disciplinary attendances must be evidenced in the relevant clinical notes or other relevant documentation.

117. They do not apply if one professional is simply supporting another, clinically or otherwise, e.g. in the taking of notes, acting as a chaperone, training, professional update purposes, operating equipment and passing instruments. They also do not apply where a patient sees single professionals sequentially as part of the same clinic. Such sequential appointments count as two separate attendances, and should be reported in line with existing Data Dictionary guidance on joint consultant clinics[43].

118. The multi-disciplinary attendance definition does not apply to multi-disciplinary meetings, where care professionals meet in the absence of the patient. Multi-disciplinary meetings should not be recorded as multi-disciplinary attendances.

Consultant led and non consultant led

119. The collection requires consultant led and non consultant led outpatient attendances to be reported separately.

120. Consultant led[44] activity occurs when a consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but takes overall clinical responsibility for patient care. The activity will take place in a consultant clinic,

[43] http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs/cds/outpatact/sharedcare

[44] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_led_activity_de.asp?shownav=1

defined as per the mandatory outpatient attendance CDS type 020, using the consultant code field[45], main specialty code and TFC.

121. Clinics run by general practitioners with a special interest (GPwSI) or specialist therapists are normally taking patients from what would have been a consultant list, and are classed as consultant led activity.

122. Non consultant led activity takes place in a clinic where the consultant is not in overall charge (i.e. any activity not covered in paragraph 120). Again, these clinics are identified in the CDS by default codes for non consultants in the consultant code field, together with the main specialty code and TFC.

HIV and AIDS

123. Nationally specified currencies HIV adult outpatient services were introduced for contracting in 2013-14[46]. The currencies are a clinically designed year of care pathway for three groupings of HIV adult patients (19 years and over). To support the currencies, the HIV and AIDS reporting system (HARS)[47] has been introduced by Public Health England. All organisations providing the HIV outpatient pathways must submit data to HARS. The dataset will support commissioning and epidemiology of HIV adult outpatient activity.

124. We are not planning to collect pathway costs for the HIV adult outpatient services in 2013-14. However, we are planning to collect the unit cost of attendances for patients with HIV or AIDS against the three categories.

125. **Category 1 (new patients)** are newly diagnosed or have newly started on antiretroviral therapy (ARV drugs). These patients, in the first year of diagnosis 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 multi-disciplinary teams. A newly diagnosed patient will be a category 1 patient for one year, after which they will automatically become a category 2 patient. 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. 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 then they become a category 3 patient for a year

126. **Category 2 (stable patients)** 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 the majority of patients and therefore should be used as the default category unless category 1 or 3 criteria can be demonstrated and validated. If a patient transfers into an HIV service and had started ARV drugs for the first time more than a year ago then they would automatically be classified as category 2 unless they had one of the complexities resulting in them being a category 3 patient.

[45] http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultant_code_de.asp?shownav=1
[46] https://www.gov.uk/government/publications/hiv-outpatient-pathway-updated-guidance-available
[47] http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVAndAIDSReportingSystem/

127. **Category 3 (complex patients)** covers patients who have a complexity needing high levels of maintenance. Complexities are:

(a) current TB co-infection on anti-tuberculosis treatment;
(b) on treatment for chronic viral liver disease;
(c) receiving oncological treatment;
(d) active AIDS diagnosis requiring active management in addition to ARV drugs (not inpatient care);
(e) HIV-related advanced end-organ disease;
(f) persistent viraemia on treatment (more than six months on ARV drugs);
(g) mental illness under active consultant psychiatric care; and
(h) HIV during current pregnancy.

128. The currencies do not include the provision of any ARV drugs. The drugs costs should be included in the unbundled high cost drug HRGs (paragraph 218), but the associated costs should be included here.

129. The costs of HIV testing and partner notification are part of sexual health and should be reported under sexual health services (paragraph 136).

Maternity outpatients and scans, screens and tests

130. Maternity outpatients include midwifery antenatal care undertaken by the NHS provider in GP and community based surgeries, which should be included as part of antenatal outpatients where the provider is able to code and electronically flow data. The setting of the outpatient clinic is irrelevant, as long as it fits with Data Dictionary definitions.

131. A number of routine scans, screens and tests are offered to mothers as an integral part of the maternity pathway. Such tests (sexual health, glucose tolerance, ultrasound etc) are often carried out in obstetrics outpatients or antenatal clinics, but also in admitted patient episodes (particularly amniocentesis, chorionic villus sampling etc).

132. Where a woman attends the hospital for an ultrasound, scan or screen as part of a non-admitted attendance, this activity should be reported as an outpatient attendance with the appropriate OPCS-4 code for any procedures or interventions carried out, which may result in a procedure driven HRG.

133. Where a woman is admitted to hospital and part of her care includes an ultrasound, scan or screen, this activity should be recorded as part of that admitted patient episode.

134. The costs of carrying out the tests should be treated as an indirect cost to the relevant maternity HRG or attendance. Pathology costs from analysing routine tests should also be treated as an indirect cost to the relevant maternity HRG or attendance. The costs of analysing samples that are undertaken under a separate commissioner contract (such as genetics, DNA, RNA, biochemistry analysis for downs syndrome, specialist diagnostic laboratories etc) should not be included in the obstetrics or maternity reference costs.

Paediatric treatment function codes

135. Providers should allocate costs and activity to paediatric TFCs in line with their Data Dictionary definition as "dedicated services to children with appropriate facilities and support staff". A small number of patients aged over 18 years also receive care in specialist children's services, including patients with learning disabilities or congenital heart disease. Such activity is assumed to have a similar resource usage to children rather than adults and should also be reported under the relevant paediatric TFC.

Sexual and reproductive health services

136. Activity that takes place in a sexual and reproductive health clinic[48] is defined by pseudo code FPC, and should be reported as non consultant led activity, regardless of the location of the clinic. It includes the costs of HIV testing and partner notification (paragraph 123).

Therapy services

137. Physiotherapy, occupational therapy, and speech and language therapy (TFCs 650, 651 and 652) should be used where referral for treatment carried out has been made by a clinical or other professional, including when accessed directly by a GP or self-referral, and where the patient attends a discrete therapy clinic solely for the purpose of receiving therapy treatment. Where these services form part of an admitted patient care episode or outpatient attendance in a separate specialty, the costs will form part of the composite costs of that episode or attendance.

Procedures in outpatients

138. Trusts should report procedures carried out in outpatients by HRG and TFC. The Grouper generates a core HRG relevant to procedures carried out in an outpatient setting, instead of a core attendance WF*** HRG.

Cancer multi-disciplinary teams

139. There is only one exception to the non face to face rule in paragraph 108 and this is for specific cancer multi-disciplinary team (MDT) meetings to discuss a patient. Cancer MDTs have been defined by the National Institute for Health and Clinical Excellence (NICE) as essential to the delivery of high quality cancer care. Although currently outside the scope of tariff, their costs may in the future be built into a specific cancer outpatient tariff and therefore an improved understanding of MDT costs is necessary.

140. Trusts should submit data against six categories of cancer MDT:

    (a) colorectal
    (b) local gynaecological - local teams diagnose most cancers, provide treatment for some types of cancer, and refer people on to the specialist teams if necessary.

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48 http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/s/sexual_and_reproductive_health_clinic_de.asp?shownav=1

(c) specialist gynaecological - specialist teams provide specialist care and treatment for people whose cancer is less common or who require specialist treatment for other reasons
(d) breast
(e) specialist upper gastrointestinal
(f) other.

141. Cancer MDTs take place in addition to and not instead of outpatient activity. Cancer outpatient clinics are often multi-disciplinary in nature and similarly MDTs can deal specifically with one type of cancer or a group of cancers.

142. The MDT meetings bring together representatives from different healthcare disciplines on a formal timetabled basis to discuss new cancer patients and agree individual treatment plans for initial treatment and on each occasion where the treatment plan needs to be varied or updated e.g. on relapse. The core role of the MDT is to resolve difficulties in diagnosis and staging and to agree a management plan. Further definitions of MDTs can be found in NICE improving outcomes guidance.

143. The activity measure for the collection is the number of individual patient treatment plans developed for each MDT. MDTs will always have a defined consultant lead, who is responsible for chairing the meeting, ensuring treatment decisions are recorded etc. Therefore, MDT costs and activity should be reported as consultant led, multi-professional, non face to face, first attendances (HRG WF02D) by MDT type.

144. A suggested methodology for costing this activity is to begin by making contact with the cancer services manager for each MDT to determine:

(a) their number, frequency and duration
(b) the staff involved
(c) the number of individual patient treatment plans developed for meetings.

145. Include consultant costs based on job plans, preparation for peer review, support staff costs, and administration costs such as arranging MDT initiated investigations and follow-up clinics. Exclude costs such as communicating the MDT outcome by phone to the patient.

146. Although an MDT may draw on membership from several NHS providers, only the host organisation responsible for its running must report the costs, including the costs of its own team and overhead costs arising from the caseloads of other organisations.

Section 5: Emergency medicine

147. This section covers all emergency medicine attendances at each of four A&E department types, defined by the sub-chapter VB HRGs, supported by the A&E minimum dataset, and split between:

    (a) patients who are admitted for further investigation or treatment rather than discharged from A&E
    (b) patients who are not admitted but are discharged or die whilst in A&E.

148. Emergency departments (national code 01) and consultant led mono-specialty accident and emergency services (national code 02) may be 24 hour or non-24 hour.

149. Other types of A&E or minor injury (national code 03) include minor injury units and urgent care centres.

150. Costs and activity for minor injuries units (MIU) should only be reported separately if:

    (a) the MIU ward is discrete, and the attendance is instead of, and has not already been counted as, an emergency medicine attendance
    (b) the MIU is not discrete but patients are seen independently of the main A&E department.

151. Where MIUs are part of an A&E department, their costs should be included as an overhead to the A&E department, and their activity excluded from reference costs, to avoid artificially reducing the average unit costs of emergency medicine attendances.

152. NHS walk in centres (national code 04) can be additionally defined as predominantly nurse-led primary care facilities dealing with illnesses and injuries - including infections and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or minor burns and strains - without the need to register or make an appointment. They are not designed for treating long-term conditions or immediately life-threatening problems.

153. A&E mental health liaison services should not be included here, but in the mental health specialist teams worksheet (paragraph 335).

154. The Grouper does not generate separate unbundled HRGs for emergency medicine. The costs of activity typically unbundled should therefore be included within the core emergency medicine HRGs.

155. Patients brought in dead (A&E patient group code 70)[49] should generally be coded and costed against HRG VB11Z, No investigation with no significant treatment.

[49] http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/a_and_e_patient_group_de.asp?shownav=1

Section 6: Unbundled services

Introduction

156. This section covers unbundled HRGs for:

    (a) chemotherapy
    (b) critical care
    (c) diagnostic imaging
    (d) high cost drugs
    (e) radiotherapy
    (f) rehabilitation
    (g) specialist palliative care.

157. Unbundled HRGs for renal dialysis for acute kidney injury are covered separately in Section 7.

158. Unbundled HRGs were developed to identify specialist services, ensure recognition of priority areas, support service redesign and patient choice, and improve the performance of HRGs so they better represent activity and costs.

159. With one exception, the costs and activity of these services should be separately identified (i.e. unbundled) from all admitted patient care and outpatients, and reported by HRG. The exception is the costs of diagnostic imaging in admitted patient care, which should not be unbundled from core admitted patient care HRGs.

160. The costs of unbundled services in A&E should not be unbundled from emergency medicine core HRGs. The Grouper will determine a single HRG only for each A&E attendance record, irrespective of the presence of care elements that elsewhere are unbundled from the core HRG.

161. With the exception of critical care, costs should be separately reported by admitted patient care, outpatient and other settings. The other category recognises that these unbundled HRGs are setting independent, and should be used where the service is delivered outside hospital (e.g. chemotherapy or rehabilitation in the home or community). It must not be used to misreport admitted patient care or outpatient care due to coding or software issues.

Chemotherapy

162. Patients receive a core HRG and one or more additional unbundled chemotherapy HRGs split into two categories:

    (a) HRGs for procurement of chemotherapy regimens according to cost band
    (b) HRGs for the delivery of chemotherapy regimens.

163. The activity measure for the chemotherapy procurement HRGs is the number of

cycles[50] of treatment and the unit cost is per average cycle. Note that the Grouper outputs the number of procurements rather than number of cycles.

164. Chemotherapy procurement HRGs are designed to cover the cost of the entire procurement service and therefore, in contrast to unbundled high cost drugs (paragraph 218), the cost of each HRG should include pharmacy oncosts (including indirect costs and overheads) as well as all other costs associated with procuring each drug cycle. The cost of supportive drugs – which are any drugs given to prevent, control, or relieve complications and side effects and to improve the patient's comfort and quality of life - should also be included within these HRGs.

165. The definitions in Table 13 may assist with costing of the chemotherapy delivery HRGs.

Table 13: Chemotherapy delivery

Definition	Explanation
Deliver simple parenteral chemotherapy	Overall time of 30 minutes nurse time and 30 to 60 minutes chair time for the delivery of a complete cycle.
Deliver more complex parenteral chemotherapy	Overall time of 60 minutes nurse time and up to 120 minutes chair time for the delivery of a complete cycle.
Deliver complex chemotherapy, including prolonged infusional treatment	Overall time of 60 minutes nurse time and over two hours chair time for the delivery of a complete cycle.
Deliver subsequent elements of a chemotherapy cycle	Delivery of any pattern of outpatient chemotherapy regimen, other than the first attendance, i.e. day 8 of a day 1 and 8 regimen or days 8 and 15 of a day 1, 8 and 15 regimen.

166. In addition to these unbundled chemotherapy HRGs, there is a core HRG (SB97Z) for a same day chemotherapy admission or attendance that is generated by the Grouper if:

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

167. SB97Z attracts a zero national price to ensure appropriate overall reimbursement where a patient is admitted or attends solely for delivery of chemotherapy and no additional activity has taken place. SB97Z will be supplied with a mandatory zero cost in the collection workbook, and therefore trusts should include any notional costs against the unbundled chemotherapy delivery HRGs.

168. Supportive care costs for cancer patients receiving chemotherapy should be allocated according to the matching principle. Therefore:

(a) the costs of services directly related to the treatment of cancer, before and after surgery, should be allocated to the appropriate surgical HRG
(b) supportive care costs not associated with the surgical procedure should be allocated to the appropriate non-surgical cancer HRG.

[50] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/anti-cancer_drug_cycle_de.asp?shownav=1

169. Chemotherapy should be reported in the following categories to reflect differences in clinical coding guidance between these settings:

(a) ordinary elective or non-elective admissions
(b) day case and regular day or night attendances
(c) outpatients
(d) other.

Ordinary admissions

170. The reporting of ordinary elective or non-elective admissions should include the core HRG and the relevant chemotherapy procurement HRGs where generated. Chemotherapy delivery HRGs will not be generated because OPCS chemotherapy delivery codes are not recorded for ordinary admissions (Table 14). The ability to deliver chemotherapy is expected to be part of the routine care delivered on a ward, and therefore costs should be reported as an overhead to the core HRG.

Table 14: Reporting chemotherapy ordinary admissions

Core HRG	Chemotherapy procurement HRG	Chemotherapy delivery HRG (crossed out)
Report in elective or non elective sheet	Report separately when generated	No delivery HRG reported as not OPCS coded

Day case and regular day or night admissions

171. The reporting of day cases and regular day or night admissions solely for the delivery of chemotherapy should include an unbundled chemotherapy delivery HRG, and may include an unbundled chemotherapy procurement HRG where the procurement of a cycle is recorded. The core HRG SB97Z will be generated for patients admitted for same day chemotherapy treatment if no other significant procedure has taken place (Table 15).

Table 15: Reporting chemotherapy day cases and regular day or night attenders

Core HRG	Chemotherapy procurement HRG	Chemotherapy delivery HRG
SB97Z Zero cost	Report separately if recorded	Report separately

Outpatients

172. Outpatients attending solely for the delivery of chemotherapy should be reported as an unbundled chemotherapy delivery HRG, and may be reported as an unbundled chemotherapy procurement HRG where the procurement of a cycle is recorded. The core HRG SB97Z will also be generated for patients attending for same day chemotherapy treatment (Table 16).

Table 16: Reporting chemotherapy outpatients

Core HRG	Chemotherapy procurement HRG	Chemotherapy delivery HRG
SB97Z Zero cost	Report separately if recorded	Report separately

Other settings

173. This setting should be used to report community chemotherapy, which describes services where patients receive their chemotherapy treatment outside of cancer centres or cancer units in facilities nearer to home such as a GP surgery or in their own homes.

Additional guidance on chemotherapy

174. Although rare, some patients may have two regimens delivered at one attendance which results in two delivery HRGs. An example is a patient receiving an intrathecal component of a regimen where this component will generate a separate procurement and delivery alongside any other regimen they may be receiving.

175. Further guidance relating to the treatment of regimens not on the national list can be found in the OPCS-4 clinical coding instruction manual[51].

176. Patients receiving both an infusion plus oral treatment as part of a single regimen on the same day will be counted as one delivery and coded to an intravenous delivery code. Patients may also receive other intravenous and oral drugs for their cancers on the same day as their chemotherapy regimen, e.g. administration of bisphosphonates. The costs of these should be attributed to the relevant core HRG and not included with the chemotherapy delivery HRG.

177. To maintain consistency with national coding guidance, the OPCS procurement and delivery codes for chemotherapy should only be used where the treatment is for systemic anti-cancer therapy, i.e. malignancy and not for the treatment of non-malignant conditions. Certain drugs appear in both the chemotherapy regimens list and high cost drugs list as they can be used to treat neoplasms as well as a range of other non-neoplastic conditions for example rheumatology. These should be coded using the OPCS high cost drugs codes and not the OPCS procurement and delivery codes.

178. Current clinical coding guidance stipulates when to code delivery of oral chemotherapy (SB11Z). If a regimen includes oral and parenteral administration, the parenteral administration determines the delivery code. SB11Z will be assigned to regimens made up of only drugs administered orally and the costs should reflect current practice in light of recommendations within the National Patient Safety Agency (NPSA) report on oral chemotherapy[52].

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[51] http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/publications/ccim

[52] http://www.nrls.npsa.nhs.uk/resources/?entryid45=59880

179. We are aware that some supportive drugs may have a disproportionately high cost compared to the other expected costs of care within the unbundled chemotherapy procurement HRG, and that some hormonal drugs may similarly have a disproportionately high cost within the core HRG. We are working towards implementing a solution to these issues. Currently the treatment of such drugs should be as per Table 17.

Table 17: Supportive and hormonal drug treatment

Method of delivery	Hormone treatments	Supportive drugs
As an intrinsic part of a regimen	If included within a regimen ignore	If included within a regimen ignore
By itself	Code to the relevant admitted patient or outpatient core HRG generated (not chemotherapy specific)	Apportion over procurement bands, potentially extra delivery time and costs
As part of supportive drug	Include costs within supportive drug costs	N/A

Critical care

180. Critical care reference costs are collected separately for:

(a) adult critical care
(b) paediatric critical care
(c) neonatal critical care.

Adult critical care

181. The adult critical care minimum dataset (CCMDS) is a sub-set of the admitted patient care dataset. A patient that is admitted to a critical care unit will have an admitted patient care dataset record for their hospital admission, which will produce a core HRG and other unbundled HRGs, and a CCMDS record producing their unbundled critical care HRG.

182. Adult critical care HRGs are based on the total number of organs supported in a critical care period. The CCMDS (ISB 0153/Amd 81/2010[53] refers) collects a wider range of organ support information. Reference costs use these organ support categories to classify cost and activity data. The costs and activity for stays in critical care should therefore be excluded from the composite cost and length of stay for the admitted patient care and a separate cost per bed day produced.

183. The Grouper will only output one HRG per critical care period. This HRG signifies the total number of organs supported, from zero to six, in that critical care period. Only if there is more than one critical care period will there be more than one critical care HRG in the episode.

184. In previous years, reference costs for adult critical care have been differentiated by the following critical care unit functions:

(a) burns critical care units

[53] http://www.isb.nhs.uk/library/standard/112

(b) spinal injuries critical care units
(c) all other critical care units.

185. For 2013-14, we are consulting on whether to further differentiate reference costs by all critical care unit functions[54] in the CCMDS:

(a) 01 Non-specific, general adult critical care patients predominate
(b) 02 Surgical adult patients (unspecified specialty)
(c) 03 Medical adult patients (unspecified specialty)
(d) 05 Neurosciences adult patients predominate
(e) 06 Cardiac surgical adult patients predominate
(f) 07 Thoracic surgical adult patients predominate
(g) 08 Burns and plastic surgery adult patients predominate
(h) 09 Spinal adult patients predominate
(i) 10 Renal adult patients predominate
(j) 11 Liver adult patients predominate
(k) 12 Obstetric and gynaecology critical care patients predominate
(l) 90 non standard location using a ward area.

186. For each of these critical care unit functions, the unit cost per bed day, total number of critical care bed days, and number of critical care periods should be reported.

187. Data for children treated in adult critical care units should be reported as part of its costs. It is not necessary to identify separately activity relating to children undertaken in an adult unit.

Critical care periods

188. Record the number of critical care periods[55] that have occurred within each hospital spell. A critical care period is a continuous period of care or assessment (i.e. a period of time) within a hospital provider spell during which a patient receives critical care in any one single unit function type of the critical care unit. A new critical care period commences with each new CCMDS record.

189. Discrepancies can arise when counting critical care bed days for all types of critical care services activity. For reference costs, counting of adult, neonatal or paediatric critical care should follow the example in Table 18.

Table 18: Critical care bed day count

	Critical care admission date and time	Critical care discharge date and time	Count
Adult with different dates of critical care admission and discharge	5 November 13:00	7 November 10.30	3 critical care bed days
Adult with same date of critical care admission and discharge	5 November 13:00	5 November 22:00	1 critical care bed day

190. Given this counting convention, a critical care bed vacated and subsequently occupied by a second patient over the course of 24 hours should be counted as two

54 http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cou/critical_care_unit_function_de.asp?shownav=1
55 http://www.datadictionary.nhs.uk/data_dictionary/classes/c/critical_care_period_de.asp?shownav=1

critical care bed days.

Costing critical care

191. We would expect the following costs to be included in the cost per critical care bed day:

    (a) medical staff
    (b) nursing and other clinical staff
    (c) therapies
    (d) ward consumables
    (e) drugs
    (f) blood and blood products
    (g) diagnostics undertaken whilst the patient is in critical care, e.g. pathology, plain film x-rays, MRIs
    (h) medical and surgical equipment (include the costs of specialist equipment, e.g. CPAP and NIPPY machines, and ensure that the costs of devices excluded from the national tariff are also reported in the reconciliation statement workbook).

192. The costs of any theatre time must be reported against the core HRG and not the unbundled critical care HRG. If a patient's TFC changes on admission to a critical care unit, a new FCE will begin, and theatre costs will not form part of the total cost for the critical care service. But even if a new FCE does not start on admission to critical care, or an FCE is wholly within critical care under a critical care consultant from admission to discharge, theatre costs should still be excluded from critical care, and reported against the core HRG.

193. Where there is no theatre time, this may result in a relatively small or even zero cost against the core HRG. In these circumstances, organisations have the discretion to exclude these zero cost HRGs on the same principle that other zero cost HRG are excluded (paragraph 47). The key principle here is that critical care represents the highest level of complexity and only the daily costs of providing critical care should be recorded against the unbundled critical care HRG. Meanwhile, costs relating to treating the patient's condition, including any surgery or theatre irrespective of setting, should be reported against the core HRG.

194. The costs of relevant high cost drugs or high cost blood products should be included in the unbundled high cost drugs HRGs (paragraph 212) and not here.

195. Many organisations have adult critical care outreach teams that operate outside the parameters of the discrete adult critical care unit. Outreach teams support general ward staff in caring for higher acuity patients, facilitate admission to and discharge from critical care, help avoid unnecessary critical care admissions, share clinical skills, and follow up patients to monitor outcomes and services. In a change from previous years, trusts should include outreach teams as an overhead to admitted patient care, and not report them as a separate total cost.

Paediatric critical care

196. Costs should be reported against the following unbundled HRGs, which are supported by the paediatric critical care minimum dataset (PCCMDS)[56] and further qualified in terms of scope on page 2 of DSCN 01/2007 version 3[57]:

XB01Z - solely for use for extra corporeal membrane oxygenation (ECMO) or extra corporeal life support (ECLS) within a designated provider and nationally commissioned. The providers in Table 19 are expected to report the majority of costs.

Table 19: Providers of ECMO, ECLS or aortic balloon pump

Code	Name
RBS	Alder Hey Children's NHS Foundation Trust
RQ3	Birmingham Children's Hospital NHS Foundation Trust
RP4	Great Ormond Street Hospital For Children NHS Trust
RJ1	Guy's and St Thomas' NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RT3	Royal Brompton and Harefield NHS Foundation Trust
RHM	Southampton University Hospitals NHS Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
RA7	University Hospitals Bristol NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust

XB02Z to XB05Z - relate to intensive care. Only the providers in Table 20 with paediatric intensive care units (PICUs) are expected to report costs. Children in an adult ICU with a CCMDS rather than a PCCMDS record have been incorrectly coded. Trusts should report these costs against UZ01Z, not sub-chapter XB, and arrange to correct their coding in future years.

Table 20: Providers with paediatric intensive care units

Code	Name
RBS	Alder Hey Children's NHS Foundation Trust
R1H	Barts Health NHS Trust
RQ3	Birmingham Children's Hospital NHS Foundation Trust
RGT	Cambridge University Hospitals NHS Foundation Trust
RW3	Central Manchester University Hospitals NHS Foundation Trust
RP4	Great Ormond Street Hospital for Children NHS Trust
RJ1	Guy's and St Thomas' NHS Foundation Trust
RWA	Hull and East Yorkshire Hospitals NHS Trust
RYJ	Imperial College Healthcare NHS Trust
RJZ	King's College Hospital NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RVJ	North Bristol NHS Trust
RX1	Nottingham University Hospitals NHS Trust
RTH	Oxford Radcliffe Hospitals NHS Trust
RT3	Royal Brompton and Harefield NHS Foundation Trust
RCU	Sheffield Children's NHS Foundation Trust

56 http://www.datadictionary.nhs.uk/data_dictionary/messages/supporting_data_sets/data_sets/paediatric_critical_care_minimum_data_set_fr.asp?shownav=1
57 http://www.isb.nhs.uk/documents/dscn/dscn2007

Code	Name
RTR	South Tees Hospitals NHS Foundation Trust
RHM	Southampton University Hospitals NHS Trust
RJ7	St George's Healthcare NHS Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
RJE	University Hospital of North Staffordshire NHS Trust
RA7	University Hospitals Bristol NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust

XB06Z to XB07Z - relate to high dependency care. This care can be delivered on children's wards in many hospitals, as well as in designated high dependency and intensive care units. Any provider may submit these costs.

XB08Z - relates to paediatric critical care transport.

XB09Z - Paediatric Critical Care, Enhanced Care. Represents the resources involved in providing critical care to children where the critical care activity codes recorded do not necessarily indicate high resource. Any provider may submit these costs.

197. The HRGs can be derived in a variety of settings. Therefore costs for delivery of critical care on children's wards, also known as non-discrete high dependency care, should be included and underpinned by the completion of a PCCMDS record. Care should be taken to ensure these costs are not double counted against the admitted patient care core HRG.

198. Unit costs for XB01Z to XB07Z inclusive and XB09Z are per occupied bed day (applying the counting convention in paragraphs 189 and 190), with each occupied bed day producing an HRG (i.e. one HRG per day).

199. Unit costs for XB08Z are per patient journey.

200. In 2006, the Casemix Service analysed the results of an observational costing study of staff resource costs in 10 paediatric intensive care units (PICU). The work is discussed in the *National report of the Paediatric Intensive Care Audit Network (PICANET), January 2004 – December 2006*[58]. The relative staff resource costs across HRGs arising from this work, and a worked example of how organisations might use these to benchmark their own reference costs returns before submission, are shown in Table 21, where we assume a hypothetical paediatric intensive care unit is delivering 5,000 bed days of activity a year at a cost of £10 million. The staff resource costs are expressed as a cost ratio with XB05Z as the reference HRG with a value of 1.00.

58 http://www.picanet.org.uk/Documents/General/Annual_Report_2007/PICANet%20National%20Report%202004%20-%202006.htm

Table 21: Using benchmark cost ratios to inform paediatric critical care reference costs

		A	B	C = A * B	D = C / Sum C * £10 million	E = D/B
HRG	Description	Cost ratio	Bed days	Weighted bed days	Total cost of weighted bed days £	Average unit cost per bed day £
XB01Z	Paediatric critical care intensive care – ECMO/ECLS	**3.06**	100	306	546,233	5,462
XB02Z	Paediatric critical care intensive care advanced enhanced	**2.12**	150	318	567,654	3,784
XB03Z	Paediatric critical care intensive care advanced	**1.40**	500	700	1,249,554	2,499
XB04Z	Paediatric critical care intensive care basic enhanced	**1.22**	1,000	1,220	2,177,794	2,178
XB05Z	Paediatric critical care intensive care basic	**1.00**	2,000	2,000	3,570,154	1,785
XB06Z	Paediatric critical care high dependency advanced	**0.91**	750	683	1,219,207	1,626
XB07Z	Paediatric critical care high dependency	**0.75**	500	375	669,404	1,339
			5,000	5,602	10,000,000	

201. Organisations may wish to use the cost ratios to assist with the compilation of their reference costs. However, they are indicative only and if organisations can provide robust cost apportionments of their own, they should use these instead. They were obtained from a study undertaken within PICUs, with a higher nursing input to a patient requiring a high dependency level of care than might be delivered to the same patient in a high dependency unit or ward setting. As a consequence, reference costs for delivering high dependency levels of care outside of PICUs would be expected to be lower.

Neonatal intensive care

202. Cost and activity for XA01Z to XA05Z should be reported on an occupied bed day basis, with each occupied bed day (applying the counting convention in paragraphs 189 and 190) producing an HRG (i.e. one HRG per day). XA06Z relates to neonatal critical care transport and should be reported using unit cost per journey, with number of patient journeys as the activity measure.

Diagnostic imaging

203. The unit of activity for unbundled diagnostic imaging (radiology) HRGs in sub-chapter RA is examinations. One HRG may account for scans of multiple body areas within the same visit to a scanner (e.g. RA05Z – Computerised tomography scan, three areas without contrast). Therefore, one scan should equal one HRG, but the scan may be of multiple body areas.

204. Diagnostic imaging should also be reported by the TFC of the outpatient clinic in which the imaging was requested. Trusts should use pseudo code 999 if they are unable to assign a TFC accurately.

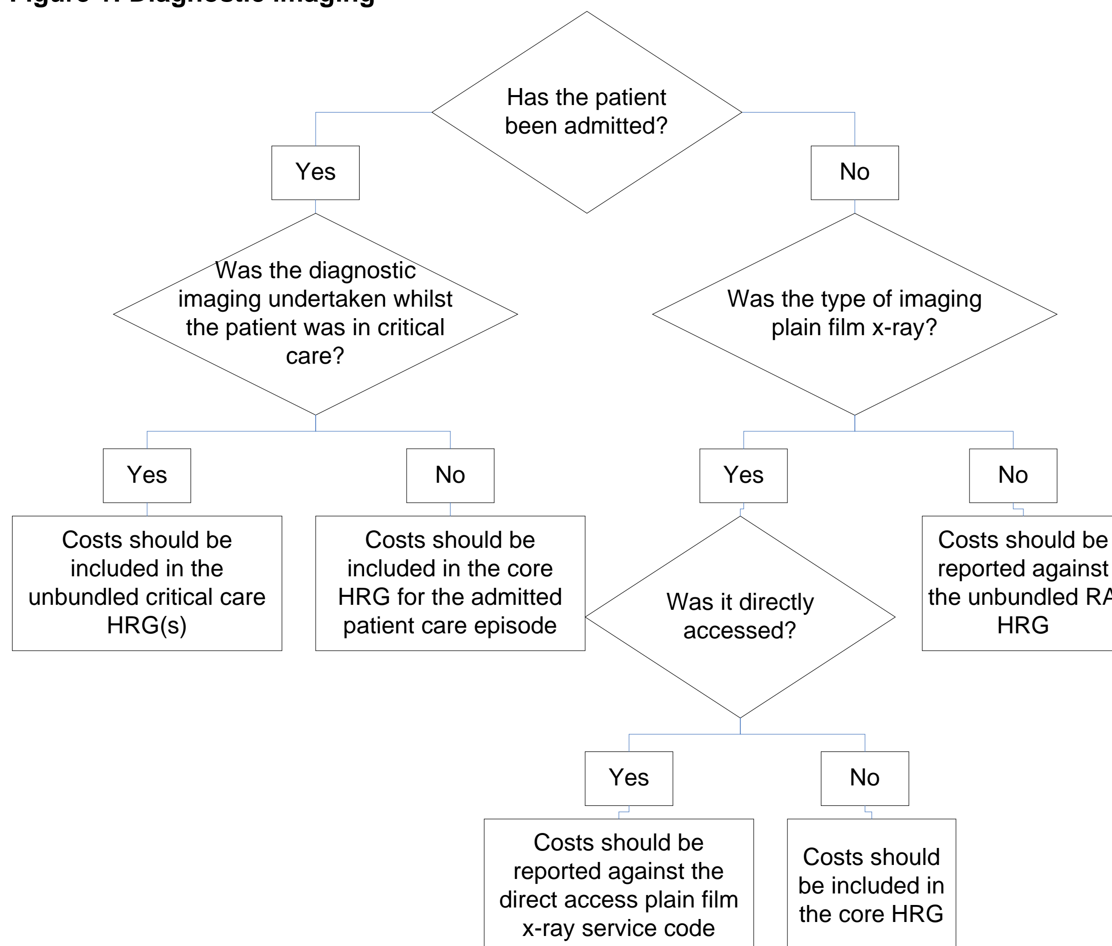
205. Plain film x-rays are not unbundled. The reporting arrangements for these, when directly accessed is covered in paragraph 279. HRGs in sub-chapter RC for interventional radiology, created to support best practice tariff policy, are core not

unbundled.

206. Diagnostic imaging should be separately reported under the following settings (Figure 1):

(a) outpatient
(b) direct access
(c) other.

Figure 1: Diagnostic imaging



207. Some diagnostic imaging is not coded in a way that generates an unbundled diagnostic imaging HRG. For example, a correctly coded obstetric ultrasound in outpatients is likely to group to one of the obstetric medicine core HRGs (paragraph 132). Costs and activity for these scans should not be unbundled, but reported within the generated core HRG.

Admitted patient care

208. The costs of diagnostic imaging in admitted patient care should be included within the core HRG. The costs of diagnostic imaging in critical care, rehabilitation or specialist palliative care should be included in the unbundled critical care, rehabilitation or specialist palliative care HRG. Any unbundled diagnostic imaging HRGs produced by the Grouper should be ignored.

Outpatients

209. Diagnostic imaging accessed as a part of an outpatient attendance should be reported here. Where no other procedures are recorded in outpatients, the Grouper will output a core outpatient attendance HRG as well as an unbundled diagnostic imaging HRG. The outpatient attendance should be reported and costed separately. However, where a patient attends for diagnostic imaging only, a core outpatient attendance HRG should not be reported.

Direct access

210. Direct access (defined in Section 8) diagnostic imaging should be reported here. A separate core outpatient attendance HRG should not be reported.

Other settings

211. Diagnostic imaging in settings other than admitted patient care (including critical care), outpatient and direct access settings should be reported here.

High cost drugs

212. Not all drugs that are high cost have an OPCS code, and therefore an unbundled high cost drug HRG. We discuss these in paragraph 86.

213. Drugs that do have an OPCS code will generate a separate unbundled high cost drug HRG in addition to the core HRG for the care episode. For reference costs, high cost drugs should be separately as follows:

    (a) admitted patient care - unit costs per spell of high cost drug HRGs produced by the Grouper
    (b) outpatients - unit cost per attendance of high cost HRGs produced by the Grouper
    (c) other settings - for other activity outside admitted, outpatient or direct access settings, the stand alone pharmacy data system should be used in the absence of clinical coding to derive the appropriate OPCS-4 code and thus generate the HRG, which should be reported on a per average attendance basis.

214. The OPCS-4 clinical coding instruction manual[59] states that high cost drugs are coded per hospital provider spell and not FCE, and usually assigned in the first episode where the drug is administered, e.g. a patient receiving a particular high cost drug 10 times in a spell would be coded once. This should result in one unbundled high cost drug HRG from the Grouper per drug, per spell.

215. Should a patient receive two different high cost drugs within a single spell, then these would be coded separately and outputted by the Grouper separately, once for the first drug and once for the second drug.

[59] http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/publications/ccim

216. It is also possible for the Grouper to output more than one of the same high cost drug HRG in a single spell when different drugs assigned to the same OPCS-4 code are delivered. For example, a patient may receive two drugs in a single spell, both of which belong to the same type of high cost drug. Coding guidance states it would be legitimate to record both drugs even though the same OPCS-4 code is used twice, because these are different drugs. The Grouper would output this as two HRGs.

217. The current HRG4+ design does not consider dosage. Taking this, and the coding guidance above into consideration, and to ensure that costs and activity are recorded consistently, the average cost of a high cost drug should be identified across the admitted patient spell or outpatient attendance.

218. The costs of each unbundled HRG should include only the actual costs of the drug. All other pharmacy oncosts, and the costs of drugs administered with high cost drugs, should remain in the core HRG.

Radiotherapy

219. The unbundled radiotherapy HRGs are similar to the design of the unbundled chemotherapy HRGs, in that an attendance may result in an additional two HRGs: one HRG for pre-treatment planning and one HRG for radiotherapy treatment. The radiotherapy dataset should be used as a source of data for submitting reference costs. This will result in the vast majority, if not all activity reported as outpatient attendances, although the collection offers the following settings for consistency:

(a) ordinary elective or non-elective admissions
(b) day case and regular day or night attendances
(c) outpatients
(d) other.

220. In addition to these unbundled chemotherapy HRGs, a core HRG (SC97Z) for a same day external beam radiotherapy admission or attendance is generated by the Grouper if:

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

221. The same principles described in paragraph 167 for SB97Z also apply to SC97Z.

222. Activity should be allocated for each fraction of radiotherapy delivered and only one fraction per attendance should be coded. The intention in HRG4+ is that each fraction would be separately counted, rather than the number of courses of treatments. However, clinical coding guidance states that only one delivery fraction should be recorded per stay. Therefore, the unit of activity for ordinary admissions is per admission, unless the patient has treatment to more than one body site when it would be permissible to record a delivery fraction for each area treated if a change in resources was identified from delivery on a single site. This will not be an issue for activity recorded in the radiotherapy dataset as outpatient. Table 22 clarifies the Grouper output for different patient settings (providing organisations have followed coding guidance) and the treatment of the data for reference costs.

Table 22: Radiotherapy outputs

Setting	HRG output from the Grouper	Treatment of HRG in reference costs
Ordinary elective or non-elective admission	Core HRG +	Report core HRG costs separately from radiotherapy costs
	Planning HRG (one coded per admission) +	Report planning costs using planning HRGs
	Delivery HRG (one coded per admission)	Report all delivery costs for the admission using delivery HRG
Day case, regular day or night attendance, and outpatients	SC97Z sameday external beam radiotherapy +	Report SC97Z at zero cost (all radiotherapy costs are reported in planning or delivery activity)
	Planning HRG (one coded per course of treatment) +	Report unit cost of planning HRG per course of treatment
	Delivery HRG (one coded per fraction delivered every appointment)	Report average cost per fraction and number of attendances
Other (for any activity not included above)		Report planning per course and delivery per fraction

223. A first outpatient attendance may result in the two HRGs described, (one planning HRG and one delivery HRG), with the follow up attendances only resulting in the delivery HRGs and SC97Z being assigned.

224. An average unit cost per treatment course should not be reported for delivery costs in day case, regular day or night attendance, or outpatient settings. Instead, cost per fraction should be reported by HRG. In addition, the number of relevant attendances or admissions that relate to the number of fractions should be reported. This additional activity data will be used for the development of tariff. Organisations should take care not to double count the activity data within the outpatient section of the return.

225. Supportive care costs for cancer patients receiving radiotherapy in an ordinary elective or non-elective setting should be allocated as set out in paragraph 168.

226. Advice from the National Cancer Action Team (NCAT)[60] highlights the need to allocate costs according to the type of radiotherapy being delivered. There are predominantly two types of radiotherapy:

(a) external beam radiotherapy and
(b) brachytherapy and liquid radionuclide administration.

227. Work to develop the brachytherapy classification is ongoing. Until this work is complete, it is important that brachytherapy costs are only reported within the current set of brachytherapy HRGs, and not within the external beam HRGs.

Rehabilitation

228. For the purposes of reference costs, rehabilitation services are those provided to

[60] http://www.cancer.nhs.uk/radiotherapy/

enable a patient to improve their health status, and involve the patient actively receiving medical attention. Rehabilitation for patients with mental health problems should be reported under mental health services and not here.

229. The unbundled rehabilitation HRGs in this collection are used to describe patients:

(a) admitted for discrete rehabilitation or
(b) treated on a discrete rehabilitation ward or unit.

230. Costs and activity should be split by the following settings:

(a) admitted patient care
(b) outpatient
(c) other.

231. Each setting is further divided as follows:

(a) complex specialised rehabilitation services level 1
(b) specialist rehabilitation services level 2
(c) non-specialist rehabilitation services level 3.

232. The Grouper will output an unbundled rehabilitation HRG for discrete rehabilitation accompanied by a multiplier showing the days of rehabilitation within the FCE, and adjust the core length of stay for this activity. Table 23 illustrates the Grouper output and the reporting requirements for reference costs.

Table 23: Reporting rehabilitation services

What happens to the patient?

Patient has hip replacement (10 days)	Patent then has discrete rehabilitation as part of admission (20 days)
Total length of stay for spell = 30 days	

What does the grouper output?

One core HRG (reported in ordinary admission worksheet)	20 unbundled HRGs (reported in rehabilitation worksheet)

What costs should be reported and where?

Length of stay = 10 days for core HRG (and excess bed day costs if applicable)	Activity = 20 days for unbundled HRG (reported in rehabilitation worksheet)

Admitted patient care

233. The activity measure for the rehabilitation delivery HRGs is occupied bed day. These HRGs are generated by the recording of OPCS U50 to U54 codes. Where a patient is not admitted specifically to a rehabilitation ward or unit, or where rehabilitation treatment is undertaken without transfer to a specialist consultant, or without transfer to a rehabilitation unit, this should not have been reported under OPCS U50 to U54 codes and thus should not be reported as discrete rehabilitation. Trusts should refer to the OPCS-4 clinical coding instruction manual for further advice.

234. If there are multiple types of rehabilitation delivery coded within a single episode, the Grouper will output an unbundled rehabilitation delivery HRG per day per

rehabilitation delivery type (as identified by the appropriate rehabilitation delivery OPCS code).

235. Trusts should therefore take care when reporting the number of rehabilitation delivery days in reference costs, to ensure that these days are not double counted, and that the number of total rehabilitation delivery days reported across all rehabilitation types for a patient does not exceed the episode duration that contains those rehabilitation delivery OPCS codes.

Outpatients

236. The activity measure for the rehabilitation assessment HRGs is attendance. These HRGs are generated by the recording of OPCS X60.1 to X60.3 codes. Coding guidance also allows these to be used for admitted patient care. Where a rehabilitation assessment procedure is not recorded in outpatients, then the Grouper will output a normal outpatient attendance HRG. Where OPCS codes have not been coded, outpatient attendances for rehabilitation should be reported under the relevant TFC in the outpatient attendance worksheet.

237. OPCS X60.1 to X60.3 codes are assessment only not delivery and coding guidance states that where a patient receives assessment and delivery during the same admission, only one code is required for the delivery from OPCS U50 to U54 as it is assumed that that assessment has already been carried out.

238. We would not expect rehabilitation delivery HRGs VC04* to VC42* to be generated in an outpatient setting because they are not generally coded. These HRGs, when generated in outpatients, should be ignored and the costs and activity reported under the outpatient attendance.

239. When an unbundled rehabilitation HRG is reported in outpatients, an outpatient procedure or attendance WF*** HRG must not be reported.

Complex specialised rehabilitation services

240. Certain aspects of rehabilitative care are delivered by specialist NHS providers. Associated with the delivery of complex specialised and specialist rehabilitation are an expectation of increased resource usage and longer durations of admitted patient care. To report the activity and costs of these as part of composite discrete rehabilitation would be to mask the extent of the resources used incurred. Therefore, to support the definitions of specialised services in the SSNDS[61], the collection requires that the NHS separately identify not only those complex specialised rehabilitations services, but also those that might be termed specialist.

241. CSRS that fall within this definition set and contain components relating to admitted patient rehabilitation are:

(a) specialised spinal services (all ages)
(b) specialised rehabilitation services for brain injury and complex disability (adult)
(c) specialised burn care services (all ages)

[61] http://www.specialisedservices.nhs.uk/info/specialised-services-national-definitions

(d) specialised pain management services (adult).

Specialist rehabilitation services

242. A specialist rehabilitation service (SRS) level 2 is one that is not designated a CSRS level 1 service but has the following characteristics:

   (a) a co-ordinated multi-disciplinary team of staff with specialist training and experience, including a consultant with specialist accreditation in the specific area of rehabilitation
   (b) carries a more complex caseload, as defined by agreed criteria
   (c) meets the national standards for specialist rehabilitation laid by the appropriate royal college and specialist societies, e.g. the British Society of Rehabilitation Medicine (BSRM) for amputee musculoskeletal and neurological rehabilitation (including stroke and brain injury rehabilitation)
   (d) serves a recognised role in education, training and published research for development of specialist rehabilitation in the field.

243. The BSRM have developed criteria and checklists for the identification of these level 2 services that conform to the standards required of a specialist rehabilitation service, which may be applied through a scheme of peer review and benchmarking of reported data to confirm service quality.

Non-specialist rehabilitation services

244. Non-specialist rehabilitation services (NSRS) level 3 are any not specialist or complex specialised and are therefore identified by exception rather than by definition. Where organisations cannot recognise themselves as either providers of CSRS or SRS, they should report as non-specialist.

Costing rehabilitation services

245. Rehabilitation should only be separately identified where discrete rehabilitation has been carried out. No attempt should be made to separately identify non-discrete rehabilitation costs during an admitted patient care stay.

246. Increasingly, rehabilitation services are provided by community hospitals following transfer from an acute provider. Community hospitals should note the following:

   (a) community hospitals providing a rehabilitation service should report this on an occupied bed day basis by HRG
   (b) when patients are admitted to a community hospital after discharge from an acute provider (i.e. a different organisation), the patient may be admitted under the previous acute HRG
   (c) community hospitals that provide rehabilitation services should submit this data as rehabilitation (i.e. because that is the service being provided), rather than using the acute HRG that relates to the condition for which the patient has undergone treatment in the acute provider
   (d) where patients are transferred from acute to community hospitals whilst in an acute stage of treatment to facilitate early discharge and still require acute care and stabilisation before rehabilitation treatment, organisations should report the acute phase of care using an appropriate specialty and HRG, and report the

rehabilitation using the appropriate rehabilitation services category
(e) it is inappropriate to report the post-acute element of care as rehabilitation, and it may be similarly inappropriate to report it as the discharge HRG from the acute provider.

247. Unbundled rehabilitation HRGs should not be used to describe the cost of activity beyond an HRG trim point for any acute or non-specified HRG. This should still be reported as excess bed days.

Specialist palliative care

248. The unbundled specialist palliative care HRGs should be reported against the following settings:

(a) ordinary elective or non-elective admissions, including support hospital teams
(b) day cases and regular day or night admissions
(c) outpatients
(d) other.

249. The unbundled HRGs include care that is provided under the principal clinical management of a specialist palliative care medicine consultant, either in a palliative care unit or in a designated palliative care programme. This care should usually be reported using main specialty codes for palliative medicine (315), nursing episode (950) or allied health professional episode (960).

250. Bereavement counselling should only be included in specialist palliative care or other HRGs in the unusual circumstance it is provided directly to the patient or, where the patient is a child, to the carer as a proxy to the child. In all other situations, it should be treated as an overhead.

Ordinary admissions

251. Specialist palliative care for ordinary elective or non-elective admissions should be reported per bed day using HRG SD01*. The Grouper will output an unbundled specialist palliative care HRG accompanied by a multiplier showing the days of specialist palliative care within the FCE, and adjust the core length of stay for this activity.

252. If a patient is not admitted under the care of a specialist palliative medicine consultant but is receiving support from a member of a specialist palliative care team, this is classed as specialist palliative care support and should be reported per bed day using HRG SD03*. The core HRG length of stay should not be adjusted for specialist palliative care support.

Day case and regular day or night attenders

253. Same day specialist palliative care should be reported under HRG SD02*. The Grouper will automatically add one bed day.

Outpatients

254. For non-admitted care, HRG SD04* should be reported for medical and HRG SD05*

for non-medical specialist palliative care attendances. A core outpatient attendance HRG should not also be reported when a patient attends for specialist palliative care only.

Section 7: Renal dialysis

Introduction

255. This section covers:

(a) renal dialysis for chronic kidney disease
(b) renal dialysis for acute kidney injury.

Renal dialysis for chronic kidney disease

256. Renal dialysis for chronic kidney disease is described by the sub-chapter LD core HRGs. These are generated from data items contained in the NRD.

257. When a patient has dialysis for chronic kidney disease, some trusts record a dialysis session (patient solely admitted for dialysis) as an outpatient or regular day admission within the CDS. This should generate the LD HRG for the dialysis, and a core HRG of LA97A or LA97B for the CDS activity. As all the costs relate to dialysis, and are reported under the LD HRG, there should be zero costs allocated to the LA97* HRGs which we have removed from the reference costs workbook.

Haemodialysis

258. The following HRGs are to be used for reporting reference costs for chronic kidney disease haemodialysis

(a) LD01* to LD04* (hospital haemodialysis)
(b) LD05* to LD08* (satellite haemodialysis)
(c) LD09* and LD10* (home haemodialysis).

259. The unit cost is per individual session, i.e. each session of haemodialysis treatment received on a given day for each patient.

260. Because the HRGs are automatically generated from the NRD it should be possible for providers to identify all activity, which may not previously have been recorded on the hospital PAS system, admitted patient care CDS or outpatient CDS, but held locally.

261. Where separate costs for patients with blood borne viruses receiving haemodialysis are identified these should include the cost differential arising from the need to provide isolation dialysis if its delivery reduces staffing flexibility and increases the capital costs through patient specific dialysis machine usage.

262. There is an additional requirement to report as memorandum information the average number of sessions per week per patient of home haemodialysis for patients aged 19 years and over. Trusts will need to liaise with their renal unit to obtain this information.

Dialysis away from base

263. There is an additional requirement to identify separately the costs and activity associated with providing haemodialysis to patients aged 19 years and over whilst they are away from their normal base. This will help ensure that national prices differentiate appropriately between the costs of dialysis away from base and at the patient's normal base. Trusts will need to liaise with their renal unit to obtain this information. Costs should be provided on exactly the same basis as for regular dialysis at the base unit.

Peritoneal dialysis

264. The LD13* HRGs describe assisted automated peritoneal dialysis (APD), and are designed to capture patients receiving APD at home with the assistance of a healthcare professional.

265. Unit cost is per day as described in the NRD and not based on the number of bags or exchanges.

266. In costing continuous ambulatory peritoneal dialysis (CAPD) and APD, the cost of the bags used for each session is a major cost driver. These bags can differ in size, so using number of bags is not a good proxy for number of sessions. Instead, patient days should be used as a proxy for sessions. The cost of the fluids for exchange, plus the operating costs of the machine facilitating the exchange in APD should be included.

Renal dialysis for acute kidney injury

267. Renal dialysis for acute kidney injury is described by unbundled subchapter LE, containing HRGs split between haemodialysis and peritoneal dialysis for adults and children.

268. About one third of patients who receive dialysis for acute kidney injury have a primary diagnosis of acute kidney injury and generate a core HRG of LA07*. The other two thirds of patients have other primary diagnoses and treatments, so the LE unbundled HRGs can be generated alongside any core HRG.

269. Each session of dialysis a patient has for acute kidney injury within admitted patient care will generate an unbundled HRG to which the costs associated with the dialysis should be assigned.

Costing renal dialysis

270. Renal medicine admitted patient care costs should be mapped accordingly to admitted patient care cost pools and not to renal dialysis except where these costs are directly related to dialysis in admitted patient care. The full range of staffing inputs should be allocated to all dialysis modalities including, but not limited to, medical and nursing staff (including erythropoiesis stimulating agents (ESA) management), nutrition and dietetic staff, social work, pharmacy and medical engineering or technical staff. Costing models must allocate these appropriately to peritoneal dialysis therapies. Costs should also include the revenue costs of buying

and maintaining buildings and equipment, allocated appropriately between the different types of dialysis.

271. Outpatient activities associated with each dialysis modality should be separately recorded and linked to the outpatient point of delivery e.g. pathology testing or drug prescriptions issued in clinics. The outpatient attendance HRGs should not be reported for patients attending for renal dialysis only

272. For dialysis undertaken using a hub and spoke configuration, the activity and costs should be recorded within the submission of the NHS provider with contractual responsibility for the delivery of the care.

273. The costs of all ESAs and drugs for bone mineral disorders should be included in the LD HRG costs. Some of these drugs should also be reported separately in the drugs and devices worksheet:

(a) the ESAs Epoetin alpha, beta and zeta, and Darbetin alpha
(b) the drugs for bone mineral disorders Cincalcet, Sevelamer and Lanthanum.

274. Patients sometimes required drugs related to associated conditions. These drug costs should be treated as any other cost of treatment and attributed at the point of delivery, or the point of commitment in outpatients, unless separately identified.

275. Patient transport services (PTS), which are a significant cost component of haemodialysis services, are excluded from reference costs and therefore must be excluded from costs reported for renal dialysis services.

Section 8: Direct access services

Introduction

276. This section covers the following direct access services[62]

(a) diagnostic services
(b) pathology services.

277. Diagnostic or pathology services that are undertaken in admitted patient care, critical care, outpatients or emergency medicine are included in the composite cost of this care. They are categorised as direct access services when carried out independently from an admission or attendance, for example when a patient is referred by a GP for a test or self-refers.

Diagnostic services

278. Patients can directly access a range of diagnostic services, including physiological and clinical measurement tests. These are identifiable in CDS release 6.2 through the direct access referral indicator field[63], and trusts should report them using the relevant HRGs.

279. Plain film x-rays are not unbundled in any setting and the composite costs should be included within the core HRG or unbundled critical care HRG irrespective of patient setting. However, direct access plain film x-ray should be reported separately alongside other direct access diagnostic services under code DAPF.

Pathology services

280. Costs and activity for the following pathology services should be submitted based on the number of tests, with the number of requests for pathology investigation[64] required as a memorandum:

(a) cytology (excluding cervical screening programmes)
(b) histopathology and histology
(c) integrated blood sciences services (including clinical biochemistry, haematology and immunology)
(d) clinical biochemistry
(e) haematology
(f) immunology

62 http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/direct_access_service_de.asp?shownav=1

63 http://www.datadictionary.nhs.uk/data_dictionary/attributes/d/den/direct_access_referral_indicator_de.asp?shownav=1

64 http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/r/request_for_pathology_investigation_de.asp?shownav=1

(g) microbiology (including bacteriology, virology and mycology)
(h) phlebotomy
(i) other.

281. Trusts may submit costs against integrated blood sciences, or separately against clinical biochemistry, haematology and immunology, but must not submit costs against both.

282. Trusts should refer to the National Laboratory Medicine Catalogue, a catalogue of pathology tests designed to support consistent, standardised reporting, which is available via TRUD (paragraph 3).

283. The Department, working with NHS Midlands and East, has also produced a toolkit to support commissioning of community (i.e. direct access) pathology services[65]. Whilst primarily intended for commissioners, providers of pathology services may also find some of the tools helpful.

284. Direct access pathology costs will vary depending on whether the service is hospital or community based. Care should be taken to include the entire cost, including costs incurred in the transportation of samples where appropriate.

[65] https://www.gov.uk/government/news/toolkit-for-commissioning-of-pathology-services

Section 9: Mental health services

Introduction

285. This section covers:

(a) adult (working age and older people) mental health services
(b) children and adolescent mental health services (CAMHS)
(c) drug and alcohol services
(d) specialist mental health services
(e) secure mental health services.

286. The currencies for adult mental health services for working age adults and older people are mental health care clusters. Care clusters were mandated for use from April 2012 by the Department of Health, and this guidance should be read alongside *Mental health payment by results guidance for 2013-14*[66].

287. The care clusters cover most services for working age adults and older people, and replace previous reference cost currencies for adult and elderly mental health services.

288. Table 24 summarises the allocation of mental health services across the reference cost currencies.

Table 24: Allocation of mental health services within reference costs

Service	Included in cluster reference costs	Included in non-cluster reference costs	Excluded from reference costs
Approved social worker services*	Yes		
Assertive outreach teams	Yes		
Crisis accommodation services	Yes		
Crisis resolution and home treatment teams	Yes		
Early intervention in psychosis services from age 14	Yes		
Eating disorder services (adult, excluding specialised eating disorders)	Yes		
Emergency clinics or walk in clinics	Yes		
Emergency duty teams (which are not emergency assessments e.g. for sectioning under the Mental Health Act)*	Yes		
Homeless mental health services	Yes		
Local psychiatric intensive care units	Yes		
Mental health counselling and therapy***	Yes	Yes	
Psychology ***	Yes	Yes	
Psychotherapy ***	Yes	Yes	
A&E mental health liaison services (psychiatric liaison)		Yes	
Adult specialist eating disorder services		Yes	
Autism and asperger syndrome		Yes	
CAMHS		Yes	

[66] https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14

Service	Included in cluster reference costs	Included in non-cluster reference costs	Excluded from reference costs
Drug and alcohol services		Yes	
Eating disorder services (children and adolescents)		Yes	
Forensic and secure mental health services		Yes	
Gender identity disorder services		Yes	
Improving access to psychological therapies (IAPT)**		Yes	
Learning disability services in high dependency or high secure units		Yes	
Mental health service for Deaf children and adolescents		Yes	
Mental health services for military veterans		Yes	
Mental health services provided under a GP contract		Yes	
Perinatal mental health services (mother and baby units)		Yes	
Primary diagnosis of drug or alcohol misuse		Yes	
Specialised addiction services		Yes	
Specialist mental health services for Deaf adults		Yes	
Specialist psychological therapies (admitted patients and specialised outpatients)		Yes	
Acquired brain injury			Yes
Learning disability services not provided in high dependency or high secure units			Yes
Neuropsychiatry			Yes

* these services are only included in clusters where NHS funded, otherwise they are excluded.
** other specialist teams.
*** Where the service is provided to a clustered user, the cost is included in the cluster. Where the service is provided to a non-clustered user, the cost is included in a non-cluster currency.

289. The collection and guidance is therefore organised from the perspective of service users and the settings in which mental health services are delivered. For non-cluster activity, the following settings apply:

(a) ordinary elective and non-elective admissions on an occupied bed day basis
(b) day care facilities on a patient day basis
(c) outpatient attendances
(d) community contacts
(e) mental health specialist teams.

290. Only mental health trusts should use these currencies. Other trusts should use HRGs.

Adult mental health services

Mental health care clusters

291. The mental health care clusters[67] for working age adults and older people, focus on the characteristics and needs of a service user, rather than the individual

67 http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_care_cluster_de.asp?shownav=1

interventions they receive or their diagnosis. The care clusters are numbered from 00-21, although 09 is not currently used and 99 is used for patients not assessed or clustered.

292. Mental health professionals rate service users using a mental health clustering tool (MHCT) that will help them determine which cluster best describes the characteristics of a particular service user.

293. The MHCT and Mental health clustering tool booklet[68] must be used by providers. The clustering tool must be used to help inform the clustering decision, and the information that is captured must be returned along with other data as part of the monthly submission to the MHMDS.

294. The clusters cover extended time periods which will often contain multiple different care interventions. For instance, whilst in cluster 3 (non-psychotic (moderate severity)) a service user might have several sessions of psychological therapies, contacts with a care coordinator and a prescription for exercise. Each cluster has an associated review period, defined as the time between reassessments, which should be taken as a **maximum rather than a minimum** period duration. However, if there is a re-assessment before the maximum review period, because of a change in their condition, this becomes the actual cluster review period for that patient.

295. Table 25 shows the clusters and their maximum review period.

Table 25: Mental health care clusters

Code	Cluster label	Cluster Review period (maximum)
00	Variance - Unable to assign mental health care cluster code	6 months
01	Common mental health problems (low severity)	12 weeks
02	Common mental health problems (low severity with greater need)	15 weeks
03	Non-psychotic (moderate severity)	6 months
04	Non-psychotic (severe)	6 months
05	Non-psychotic (very severe)	6 months
06	Non-psychotic disorders of over-valued ideas	6 months
07	Enduring non-psychotic disorders (high disability)	Annual
08	Non-psychotic chaotic and challenging disorders	Annual
09	Blank cluster[69]	Not applicable
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder (difficult to engage)	6 months
18	Cognitive impairment (low need)	12 months
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months

[68] Annex 7C in the consultation documents published at http://www.monitor.gov.uk/NT
[69] Cluster 09 will not be available in the workbook

Code	Cluster label	Cluster Review period (maximum)
21	Cognitive impairment or dementia (high physical need or engagement)	6 months
99	Patients not assessed or clustered	N/A

Costing the mental health care clusters

296. Mental health providers should cost their services to the same costing principles set out in *Approved Costing Guidance* that apply to all NHS providers, and to the costing standards set out in the *HFMA Clinical Costing Standards for Mental Health.*

297. The key to costing accurately at cluster level is having the activity and interventions recorded by service user and the cluster assigned appropriately so costs can be built up by service user and then by cluster.

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298. Due to the nature and length of mental health care clusters, with some beginning in one financial year and running to the next, and others having a length of 12 months or more, unit costs will be per cluster per day (produced using the length of clusters falling in the reference costs year, expressed in days, similar to an acute spell or episode, and the costs of interventions within them) not per completed cluster basis.

299. The non-cluster collection generally excludes activity which continues into the next reporting year (paragraph 37). To take account of the potential length of some of the mental health care clusters **all activity and costs which occur in the financial year must be reported**, regardless of whether the clusters have completed.

300. The clusters are designed to be setting independent. However, we will continue to collect initial assessments separately, and memorandum costs and activity for:

    (a) admitted patient care
    (b) non-admitted patient care, covering outpatients, day care and community, and defined as the difference between the total number of cluster days and the number of cluster days in admitted patient care.

301. Trusts should take care to ensure that the quantum is equal to the total of the cluster day costs and the initial assessment costs.

302. Table 26 summarises the data that we will collect.

Table 26: Care cluster worksheets

Field	Comments
Cluster costs (MHCC worksheet)	
Unit cost per day per cluster	Average/weighted cost per day per service user per cluster. This is a calculated field, equal to: (Unit cost per occupied bed day x Number of cluster days in admitted patient care + Unit cost per non-admitted cluster day x Number of cluster days in other settings) / Number of cluster days within the financial year
Number of cluster days within the financial year	Total number of patient days within each cluster within the financial year. This is a calculated field, equal to: Number of cluster days in admitted patient care + Number of cluster days in other settings

Field	Comments
Memorandum information	
Unit cost per occupied bed day	This covers admitted patient care on an occupied bed day basis covering ordinary elective and non-elective activity, including leave days. It is unlikely that service users in clusters 01 to 03 would have admitted patient days. If a service user is admitted but still being seen by community or outpatient staff the cost and activity for all care must be recorded under admitted patient care for the period the user is admitted.
Number of cluster days in admitted patient care	
Unit cost per non-admitted cluster day	This is the cost per day based on the number of days between the start and finish (or year end) of the cluster review periods, when the service user was not in admitted patient care. It is not the number of contacts. Refer to the note in the row above if there is an overlap of care.
Number of cluster days in other settings	
Total number of completed cluster review periods	Total number of review periods in each cluster. If a service user has been allocated to a cluster more than once during the year, each separate time should be counted. A reassessment resulting in the service user remaining in the same cluster **does** result in a new review period. Only completed review periods should be included, part review periods at the beginning and end of the year should not be counted. Where there is an annual review period, record 1 here.
Average review period (days)	Average length of a cluster review period. This is the average interval between review dates for each service user expressed in days. Only completed review periods should be included in the average calculation, part review periods at the beginning and end of the year should not be counted. Where there is an annual review period, record 365 here or actual length if available
Initial assessments (MHCCIA worksheet)	
Unit cost per initial assessment	This covers the costs and activity associated with initial assessments of service users which helps clinicians to allocate them to clusters. Initial assessment and clustering of service users can require significant professional resource, and are therefore identified separately rather than included as an overhead for service users who are clustered.
Number of initial assessments	

303. The initial assessment period begins when a mental health trust receives a new referral from a GP or elsewhere. Where the assessment is to determine whether someone will be clustered or not, experience to date suggests that this will normally be completed within two contacts in a community setting or two working days in an admitted patient setting. This can be used as a proxy if actual data is not available. The assessment is completed when the individual is either allocated to a cluster or not allocated, for example discharged (cluster 00).

304. The clusters on the care cluster worksheet (MHCC) should only include costs and activity incurred for a service user who has been allocated to a cluster. Costs and days incurred prior to clustering will be allocated to the appropriate cluster on the initial assessment worksheet (MHCCIA).

305. The worksheets includes separate lines for:

(a) unable to assign mental health care cluster code (cluster 00) – record costs for a service user who has been assessed but has not been allocated a cluster, including the cost of their initial assessment on the initial assessment worksheet. Service users discharged after initial assessment would have their initial assessment recorded on the MHCCIA worksheet in cluster 00

(b) patients not clustered or assessed (cluster 99) - record costs incurred for treatment before a service user has been fully assessed and allocated to a cluster. This will include service user costs close to the year-end where the initial assessment costs fall into both years and the cluster is allocated after the year end. We do not want to include part year costs in initial assessments, so initial assessment costs before and after the year end will remain in cluster 99

on MHCCIA.

306. Once a service user has been assessed and placed into a cluster, the cost of the initial assessment is coded to the correct cluster on the MHCCIA worksheet, not the MHCC worksheet.

307. The cost of re-assessment should be included in the cluster the user is assigned to, at the time of the re-assessment, rather than the new cluster if the cluster changes. Re-assessment that does not result in a change of cluster will be recorded as a new review period.

308. Patients who did not attend (DNA) are not collected separately and the costs, but not activity, should be included as an overhead within the relevant cluster pathway. The same approach to DNAs applies to the non-cluster currencies.

309. The number of complete review periods and their average length should be returned in the memorandum columns. Where a review period is part completed during the year it should not be included. The intention is not to remove work in progress from the cluster cost and organisations must provide costs for the full period of care in the financial year. A review period for 12 months (clusters 07 to 13) is likely to cross two financial years, and should be reported as one review of 365 days.

310. Table 27 describes a service user who changes cluster. The service user is assessed and spends 28 days in cluster 14 at a cost of £1,000. They are reviewed and re-clustered to cluster 15, spending 20 days there at a cost of £2,000. They are re-reviewed and returned to cluster 14, where after being reviewed at 28 day intervals, spend the remaining 70 days until the end of the year at a cost of £4,000. Note the 16 days to the year-end are not counted as a review period or in the average review calculation.

Table 27: Service user change of cluster

Cluster	Total cost	Number of cluster days within the costing period	Unit cost per day per cluster	Total number of complete review periods	Average completed review period (days)
14	£5,000	28 + 72 = 100	£50	3	28
15	£2,000	20	£100	1	20

311. Table 28 describes a service user who is assessed multiple times in-year within a cluster. The service user is assessed as cluster 15 at a cost of £9,000 to the first review after 28 days and is confirmed to remain in cluster 15, where they spend 26 more days at a cost of £5,500. They are re-reviewed and stay in cluster 15, where they spend the remaining eight days until the end of the year at a cost of £1,000. There are two review periods, with an average review period of 27 days (26 + 28 / 2). The part review period to the year end is ignored for the average calculation and the number of review periods.

Table 28: Multiple assessment of service user

Cluster	Total cost	Number of cluster days within the costing period	Unit cost per day per cluster	Total number of service review periods	Average review period (days)
15	£15,500	28+26+8=62	£250	2	27

312. Because they cover extended time periods, mental health trusts should include the costs of sub-contracting services to non-NHS providers, including the voluntary sector, in the clusters.

Child and adolescent mental health services

313. CAMHS should be reported in the following settings:

(a) ordinary elective and non-elective admissions on an occupied bed day basis
(b) day care facilities on a patient day basis
(c) outpatient attendances
(d) community contacts.

314. In 2013-14 we are also providing sub-categories for:

(a) CAMHS, Admitted Patients, Psychiatric Intensive Care Unit
(b) CAMHS, Community Contacts, Crisis Resolution Home Treatment.

315. Child and adolescent drug and alcohol, eating disorder and secure services are reported separately.

Drug and alcohol services

316. Drug and alcohol services are provided for service users who do not have a significant mental health need, and have different commissioning routes and information systems from mainstream mental health services. They are therefore reported separately, split by adult and child and adolescent services, in the following settings:

(a) ordinary elective and non-elective admissions on an occupied bed day basis
(b) outpatient attendances
(c) community contacts.

Specialist mental health services

317. The following specialist mental health services should be reported separately:

(a) specialised services for Asperger syndrome and autism spectrum disorder (all ages)
(b) child and adolescents eating disorder services
(c) adult specialist eating disorder services
(d) gender identity disorder services
(e) mental health service for Deaf children and adolescents
(f) mental health services for veterans

(g) specialist perinatal mental health services (in-patient mother and baby units and linked outreach teams)
(h) specialist mental health services for Deaf adults
(i) other specialist mental health services.

318. Note that (d), (e), (f) and (h) above are being introduced for the first time in 2013-14. We would welcome feedback on what other services trusts have previously included in (i), other specialist mental services, and whether this currency should be retained.

319. These services should be reported in the following settings:

(a) ordinary elective and non-elective admissions on an occupied bed day basis
(b) outpatient attendances
(c) community contacts.

Secure mental health services

320. Providers of secure mental health services should submit unit costs and activity based on occupied bed days for:

(a) low secure services
(b) medium secure services
(c) high dependency secure provision
  (i) women's services
  (ii) mental health or psychosis
  (iii) learning disabilities
  (iv) personality disorder
(d) high secure units
  (i) women's services
  (ii) mental health or psychosis
  (iii) learning disabilities
  (iv) personality disorder
  (v) dangerous and severe personality disorder
(e) child and adolescent secure services
  (i) low
  (ii) medium
  (iii) high.

Settings for non-cluster activity

Ordinary elective and non-elective admissions

321. Costs and activity should be submitted by occupied bed day. Some admitted patient care within mental health services includes trial periods of time where patients are on home leave. They are not discharged but sent on leave to return as an admitted patient at a future date. This sometimes creates an anomaly where their beds may be used for other admitted patients, resulting in bed occupancy levels of over 100%.

322. Organisations should ensure that the reported total number of occupied bed days for a ward does not include any leave day activity unless the bed is held open for that patient to return to, i.e. that no other patient uses the bed in their absence. This rule

also applies to patients transferred temporarily to an acute provider for treatment.

323. Where the PAS does not record home leave, the activity levels will need to be adjusted manually. The key rule is to ensure that multiple occupancy above 100% is not reported, as this would have the artificial effect of diluting the unit costs.

Day care facilities

324. Costs and activity for mental health services provided in day care facilities[70] should be submitted on the same basis as for other patients using these facilities (paragraphs 395 to 398).

325. It is usually considered that day care facilities have consultant input and undertake patient assessments, whereas a community mental health team group contact (paragraph 330) would not necessarily involve a consultant and may not involve patient assessments.

Outpatient attendances

326. Costs and activity should be reported for attendances and non face to face contacts. Where consultants have a clinical caseload within a specialist team, e.g. criminal justice liaison team, the costs and activity should be reported against the specialist team currencies (paragraph 335). Where consultants do not have a clinical caseload within a specialist team, costs and activity should be reported in an outpatient or community (paragraph 330) setting.

327. The key to determining whether activity should be reported in an outpatient or community setting is as follows:

    (a) if the appointment is booked into a clinic list for a specific clinic session, including clinics in a residential home, where a consultant sees more than one patient in that clinic and location, then report in an outpatient setting
    (b) otherwise it should be reported in a community setting, e.g. a home or domiciliary visit or a visit to a single client in a residential home.

328. Primary consultations, e.g. telephone or informal contact, before the patient attends for a traditional first appointment (including mental health services such as CAMHS and community mental health teams) should not be recorded as an attendance. Rather, the cost of such contacts should form part of the unit costs of contacts with clients once accepted for treatment by the relevant service.

329. Domiciliary visit payments are now only paid in limited circumstances, or to those consultants who have chosen to retain the old consultant contract (section 12(2) 2003). The distinction to be made for reference costs is between:

    (a) a service user seeing a consultant in a clinic, which should be categorised as an outpatient attendance
    (b) a consultant seeing a service user at home, which should be categorised as a

70 http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?shownav=1

community contact.

Community contacts

330. Costs and activity should be reported for face to face and non face to face patient contacts with consultant led community services or community mental health teams (CMHT). CMHTs are teams of variable sizes, comprising a combination of staff from qualified and unqualified disciplines including social workers, community mental health nurses, occupational therapists, psychiatrists, psychologists, counsellors and community support workers (e.g. home helps).

331. Although it is rare for patients to meet more than one discipline (i.e. qualified professional staff group within each CMHT) at a single time, when this does occur the reason is for very different purposes and therefore should be recorded for reference costs.

332. Table 29 describes this process.

Table 29: Reporting patient contacts with multi-disciplinary community mental health teams

Discipline meeting	No of patients	Professionals	Report as
Discipline A	1 Patient	Same discipline 1 Professional	1 patient contact
Discipline A Discipline A	1 Patient	Same discipline 2 Professionals	1 patient contact
Discipline A Discipline A	1 Patient 1 Patient	Same discipline 2 Professionals	2 patient contacts
Discipline A Discipline B	1 Patient	Different discipline 2 Professionals	2 patient contacts
Discipline A Discipline B	1 Patient 1 Patient	Different discipline 2 Professionals	4 patient contacts

333. The exception to this general principle is when two or more professionals from the same discipline meet a single patient, at the same time, but for a different purpose (Table 30).

Table 30: Reporting patient contacts with two or more professionals from the same discipline

Discipline meeting	No of patients	Professionals	Report as
Discipline A Discipline A	1 Patient	Same discipline 2 Professionals Different purpose	2 patient contacts

334. Where CMHTs include social workers funded by social services, in addition to NHS funded staff, only the cost and activity of the NHS funded staff should be included in the reference cost return.

Mental health specialist teams

335. Most cost and activity data for services undertaken by mental health specialist teams (MHST), using currencies based on the annual national survey of investment in adult mental health services[71], should now be included in the care clusters. Remaining costs and activity should be reported on a patient contacts basis for:

(a) A&E mental health liaison services
(b) CAMHS
(c) criminal justice liaison
(d) drug and alcohol services
(e) eating disorder services
(f) forensic community
(g) IAPT
(h) prison health
(i) other.

336. Where consultants have a clinical caseload within a MHST, their costs and activity should be reported with the team.

[71] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/140098/FinMap2012-NatReportAdult-0308212.pdf

Section 10: Community services

Introduction

337. This section covers:

- (a) allied health professionals
  - (i) dietitian
  - (ii) occupational therapist
  - (iii) orthoptist
  - (iv) orthotist
  - (v) physiotherapist
  - (vi) podiatrist
  - (vii) prosthetist
  - (viii) speech and language therapist
  - (ix) other therapist
- (b) health visiting and midwifery
  - (i) health visitor
  - (ii) midwife
- (c) medical and dental services
  - (i) community dental services
  - (ii) community paediatric services
- (d) nursing
  - (i) specialist nursing
  - (ii) district nurse
  - (iii) nursing services for children
  - (iv) school based children's health services
- (e) audiology services
- (f) day care facilities
- (g) health promotion
- (h) intermediate care teams
- (i) wheelchair services.

338. One of the challenges for reference costs for community services has been the lack of a standard minimum data set and detailed service descriptions for the majority of services commonly classified as community services. The introduction of the Community Information Data Set (CIDS)[72] for local implementation from April 2012, and full compliance by April 2014, therefore marks a significant step forward.

339. Some services described in this section can be provided in a number of settings. Where they are provided as part of an admitted patient care or outpatient attendance, the costs should be reported within the composite cost of the admitted patient care or outpatient attendance HRG. Otherwise, activity and costs for these services when provided in the community, including when directly accessed, should be reported in this section.

340. As these services are delivered in a range of settings, input from other health professionals, including practice nurses will occur. All relevant costs have to be

[72] http://www.ic.nhs.uk/comminfodataset

included to ensure comparability and the key issue is the cost of services and not the funding stream.

341. This guidance also applies to outreach services. These services reflect changes in the way health services are being delivered with less clearly defined boundaries around service delivery. For a number of services, this can result in the same staff delivering services in ward settings in acute hospitals and outside such settings to provide continuity of care to patients.

Definitions

342. Unless otherwise stated for a particular service (e.g. wheelchair services), the activity measure used to derive a unit cost for all services in this section is the number of care contacts[73] and related activities for a patient within the reference costs year. The cost, but not the activity, of care contacts that were cancelled by either the provider or the patient or where the patient did not attend should also be included as an overhead.

343. This should include all face to face contacts with the patient, or a proxy such as a relative or carer e.g. the parent of a young child, where this is in lieu of a contact with the patient. Only activity that entails contact with the patient or proxy should be included.

344. Where both the patient and relative/carer are present this should be recorded as a patient contact. For example, it does not matter if a health visitor sees the parent, baby or both; this should be recorded as one contact.

345. Non face-to-face contacts should only be included where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the ramifications of test results to a patient would be included, but texting or emailing results would not. Non face-to-face telephone contacts solely to inform patients of results are excluded.

346. Group activities, i.e. where a healthcare professional meets several patients at the same time, should be included where this is linked to the individual patient e.g. group therapy. Group sessions that are not linked to an individual patient should be reported as a Group session.

347. Contacts about the patient but not involving the patient or their proxy should not be recorded as a care contact.

348. Where group sessions[74] are reported in this section (e.g. group therapy[75]), the activity measure used to derive a unit cost is the number of sessions irrespective of the size of the group involved or the number of health professionals running the

[73] http://www.datadictionary.nhs.uk/data_dictionary/classes/c/care_contact_de.asp?shownav=1

[74] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/g/group_session_de.asp?shownav=1

[75] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/g/group_therapy_de.asp?shownav=1

session, e.g. two therapists running a session for 20 people has an activity count of one. Cancelled group sessions should not be reported as an overhead.

349. Only group sessions that cannot be directly linked to each of the patients attending the group session should be included i.e. group therapy linked to each individual patient should be reported as a care contact and excluded from this group.

350. There is no information standard defining the difference between an outpatient attendance and a community care contact. Trusts should exercise their own judgement, but as a general rule of thumb a healthcare professional travelling to the patient should be treated as care contact and reported in this section, whilst a patient travelling to healthcare professional should be treated as an outpatient attendance and reported in Section 4.

351. Twilight or evening or services offered as an extension to a community nursing service should be reported under the appropriate category (e.g. district or specialist nursing).

Allied health professionals

352. Reference costs in 2013-04 will cover the following allied health professionals (AHPs)[76]

    (a) dietitian
    (b) occupational therapist
    (c) orthoptist
    (d) orthotist, further split into
        (i) care contact
        (ii) appliance cost – unit cost per appliance issued
    (e) physiotherapist
    (f) podiatrist
    (g) prosthetist
        (i) care contact
        (ii) prostheses cost – unit cost per prostheses issued
    (h) speech and language therapist
    (i) other therapist.

353. We are collecting reference costs for orthoptists, orthotists, and prosthetists for the first time in 2013-14. Appliance costs should be reported separately from the staff and service costs. We are therefore removing discrete external aids and appliances (e.g artificial limbs, orthoses, shoes and wigs) from the exclusions list.

354. We are adding an additional category of therapist in 2013-14, called Other Therapist. This currency covers other care professional staff groups defined in the Data Dictionary: art therapist, drama therapist, music therapist. It also covers therapists in complementary or alternative medicine where these services are provided discretely.

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76 http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/card/care_professional_staff_group_for_community_care_de.asp?shownav=1

355. Therapist services are further sub-divided into:

(a) adult one-to-one
(b) adult group
(c) children one-to-one
(d) children group.

356. We are splitting podiatrist services into the following currencies for the first time in 2013-14[77]:

(a) core podiatry – foot problems including dermatological conditions, corns, callus and fissures, diabetes management, nail surgery procedures, vascular assessments, wound management, falls prevention advice and patient education
(b) specialist and other podiatry.

Health visitors and midwifery

Health visitors

357. For 2013-14 we are introducing revised currencies for health visitors that are consistent with the Healthy Child Programme. The currencies, which include an indication of time spent with the parent or baby for each visit, are as follows:

(a) ante-natal review (1 hour)
(b) new baby review (2 hours)
(c) 6-8 weeks check (1 hour)
(d) 1 year review (1 hour)
(e) 2 to 2.5 years review (2 hours)
(f) other clinical interventions to provide parenting support on specific issues, e.g. behaviour management, breast feeding, post-natal depression, toilet training and weaning (30 minutes).

358. We are introducing a separate currency for Family Nurse Partnership (FNP) programmes delivered by family nurses, in recognition of their more resource intensive nature.

359. We are also introducing currencies covering health visitors'

(a) safeguarding and other statutory contacts with the parent or baby, including child assessment frameworks, child protection meetings, children in need, looked after children, serious case reviews, and supporting families with complex needs, further sub-divided into:
    (i) face to face
    (ii) non face to face
(b) public health contacts with the parent or baby, including clinics, children's centres, and early years settings, further sub-divided into
    (i) face to face

[77] These currencies are broadly based on the AQP implementation pack for podiatry services at https://www.supply2health.nhs.uk/AQPResourceCentre/AQPServices/PTP/Pages/AdultPodiatry.aspx

(ii) non face to face.

360. Trusts should continue to report immunisations separately at full cost (including travel costs), on the same basis as school based children's services (paragraph 374).

Midwifes

361. Community midwifery services have been divided into:

(a) ante-natal visits
(b) home births
(c) post-natal visits.

Medical and dental services

Community dental services

362. Community dental services generally covers dental care provided in community settings for patients who have difficulty getting treatment in their "high street" dental practice and who require treatment on a referral basis, which is not available in a general dental care setting. We are revising the currencies in 2013-14 to cover:

(a) community dental services - community dentistry for those patients who are unable to access NHS dentistry locally, or who require specialist intervention or need a home visit. Include here the costs and activity of face to face dental officer activity in clinics, and screening contacts that these officers carry out in schools (where each child screened constitutes a contact, since each requires one-to-one activity). The unit cost is per care contact
(b) general dental services – some community trusts provide a full range of NHS dental treatment for patients in a high street setting. The unit cost is per attendance
(c) emergency dental services – also known as dental access services. The unit cost is per attendance
(d) oral health promotion – the unit cost is per one-to-one session or group session.

363. We are removing emergency dental services and primary dental services from the list of services excluded from reference costs in Section 13.

Community paediatric services

364. Community paediatric services should be reported in Section 4 under TFC 290 and not here.

Nursing

Specialist nursing services

Specialist nursing services are disaggregated by the bands in

365. Table 31, split further by adult or child and face to face or non face to face.

Table 31: Specialist nursing service bands

National code	Description	Comment
N06	Active Case Management (Community Matrons)	
N07	Arthritis Nursing/Liaison	
N08	Asthma and Respiratory Nursing/Liaison	
N09	Breast Care Nursing/Liaison	
N10	Cancer Related	
N11	Cardiac Nursing/Liaison	
N12	Children's Services	See paragraph 367
N14	Continence Services	Exclude costs relating to patients in regular receipt of supplies (e.g. continence pads, stoma bags) which should be reported against home delivery of drugs and supplies (paragraph 469) in Section 13
N15	Diabetic Nursing/Liaison	
N16	Enteral Feeding Nursing Services	
N17	Haemophilia Nursing Services	
N18	HIV/AIDS Nursing Services	Includes follow up of HIV care, psychosocial support, treatment support for individuals starting or switching therapy etc
N19	Infectious Diseases	
N20	Intensive Care Nursing	
N21	Palliative/Respite Care	
N22	Parkinson's and Alzheimers Nursing/Liaison	
N23	Rehabilitation Nursing	
N24	Stoma Care Services	See comment under Continence Services
N25	Tissue Viability Nursing/Liaison	
N26	Transplantation Patients Nursing Service	Includes patients on pre and post transplantation programmes
N27	Treatment Room Nursing Services	To be used for nursing staff based in GP surgeries
N28	Tuberculosis Specialist Nursing	
N29	Other Specialist Nursing	e.g. sickle cell

366. Specialist Nursing – Community Cystic Fibrosis should be included in the year of care currencies for cystic fibrosis (Section 13).

Nursing services for children

367. In addition to specialist nursing services, the NHS provides a range of other nursing services for children including:

(a) vulnerable children support, including child protection and family therapy
(b) development services for children, including psychology
(c) paediatric liaison
(d) other child nursing services not included in specialist nursing and school based child health services, including looked after children nurses.

368. These services should be reported as one composite group using total community contacts in the reference costs year as the activity measure.

369. The following should be noted for child protection services, where separate to

services performed by community paediatricians (paragraph 108):

(a) in general, the cost of child protection is an overhead to nursing services for children. Activity included should relate to the number of total face to face contacts in a given financial year, not the number of children on the register
(b) funding received from non-NHS bodies, e.g. social services or the police, should be netted off expenditure incurred in line with the matching principle
(c) where the service is advisory to other elements of health care, and there is no contact with children, costs should be apportioned between the service areas that receive advice
(d) for consistency with other reference cost definitions, the activity relating to meetings about the patient are not counted for reference costs. The costs of these meetings should be included as an overhead and apportioned as appropriate
(e) the above advice is applicable to all child protection teams, including those that consist of a team of consultants and nurses.

District nursing services

370. Organisations should make every effort to map district nursing services to the specialist nursing bands. Only if this is not possible should organisations report against district nursing, split by face to face and non face to face.

School based children's health services

371. A number of health services and checks are performed through educational facilities. School based children's health services include all services provided in the school setting, and not just nurses that are school based and providing health services. While having significant levels of nursing input, they also have input from community paediatricians. For reference costs, they have been divided into:

(a) core services, including school entry review and year 6 obesity monitoring, further sub-divided into
    (i) one to one
    (ii) group single professional
    (iii) group multi professional (using the same definition of multi professional in paragraph 114)
(b) other services, including routine medical checks, sexual and reproductive health advice, family planning, smoking cessation, substance misuse advice and support, obesity and behaviour management (sleep, diet, healthy lifestyles, relationships etc), further sub-divided into
    (i) one to one
    (ii) group single professional
    (iii) group multi professional
(c) vaccination programmes.

372. The activities suggested for each category above are not exhaustive, may not all be undertaken by providers and may be known by a different name. Core and other services should be reported using total community contacts in the financial year. In costing all school based services, the full cost of delivering these services, not just associated nursing costs, should be included.

373. In addition, there is a requirement to report activity for school based vaccination programmes (including MMR, tuberculosis and meningitis) using the number of vaccinations given in a year as the currency, and unit cost per child. For example, two vaccinations from a course of three given in the year counts as two, which allows for uncompleted courses. Vaccinations may be equated with number of injections given. The unit cost should include all costs (including administration, nursing and medical costs) where these are part of the service costs, as well as the cost of vaccines.

374. Vaccination programmes jointly funded by GPs or non-NHS providers, or provided by a GP and administered by a school based nurse are excluded from reference costs.

Audiology services

375. This section covers audiology attendances[78] and services delivered within discrete audiology departments, following referral from an ear, nose and throat (ENT) outpatient clinic or accessed directly. We have made a number of changes for 2013-14 to:

(a) incorporate new HRGs for hearing assessment
(b) ensure no costs relating to audiology services are excluded from reference costs.

Assessment

376. The assessment HRG currencies are:

(a) CA37A, Audiometry or Hearing Assessment, 19 years and over
(b) CA37B, Audiometry or Hearing Assessment, between 5 and 18 years
(c) CA37C, Audiometry or Hearing Assessment, 4 years and under
(d) CA43Z, Balance Assessment.

377. The OPCS-4 procedure codes underpinning these HRGs are:

(a) Pure tone audiometry
(b) Balance assessment
(c) Hearing assessment
(d) Other specified diagnostic audiology
(e) Unspecified diagnostic audiology.

378. Trusts should report these HRG costs in Section 4. Trusts that are not capturing these procedure codes in outpatients may report them here.

379. The unit cost is per hearing assessment.

[78] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/audiology_attendance_de.asp?shownav=1

Fitting

380. The fitting aid currencies are:

   (a) fitting of hearing aid - adult
   (b) fitting of hearing aid - child (specialist audiology services), commissioned by NHS England
   (c) fitting of hearing aid – child, commissioned by CCGs
   (d) fitting of hearing aid or device for tinnitus.

381. The unit cost is per fitting.

Hearing aid

382. We have removed the distinction between digital hearing aids and analogue hearing aids, which have been largely phased out.

383. From 2013-14, the hearing aid currencies are:

   (a) adult hearing aid fitted under an AQP contract
   (b) adult hearing aid fitted under a non-AQP contract
   (c) child hearing aid

384. The unit cost is the (fully absorbed) cost per hearing aid fitted.

385. Costs of other repairs, moulds, tubes etc. should be included in the fitting or aftercare services rather than against the actual hearing aid.

Follow-up

386. The follow-up currencies cover follow-up appointments for adults or children after fitting, as well as the review appointment prior to adult patients being discharged back to their GP, and are:

   (a) follow-up, adult, face to face
   (b) follow-up, child, face to face
   (c) follow-up, non face to face (e.g. telephone or postal questionnaire).

Aftercare

387. The aftercare currency covers costs associated with:

   (a) cleaning advice and cleaning aids for patients with limited dexterity
   (b) battery removal devices for those with limited dexterity
   (c) replacement of batteries, tips, domes, wax filters and tubing, where required
   (d) replacement or modification of ear moulds
   (e) repair or replacement of faulty hearing aids on a like for like basis
   (f) provision of patient information.

388. In addition, we are introducing separate currencies to cover the maintenance and programming of bone anchored hearing aids (BAHA) and cochlear implant. These costs do not form part of the HRG costs and were previously excluded from reference

costs.

389. The aftercare currencies are:

(a) aftercare
(b) maintenance and programming, BAHA
(c) maintenance and programming, cochlear implant.

390. The unit cost is per episode of aftercare.

Neonatal screening

391. Trusts should report the unit cost per NHS Newborn Hearing Screening Programme attendance. The costs of follow-up interventions should be included in the admitted patient care or outpatient return against the appropriate HRG.

Other audiology services

392. As well as hearing tests, a range of other rehabilitative services are provided through audiology departments, e.g. auditory processing disorders, communication groups, environmental aids sessions, lip reading, relaxation classes, vestibular rehabilitation therapy. We would welcome advice from the service about suitable currencies for these other services. In the meantime, we propose that these costs should be included against the following currencies if they do fit with any other currency provided in this guidance:

(a) rehabilitative audiology services (one-to-one) – the unit cost per care contact
(b) rehabilitative audiology services (group) – the unit per group session.

393. The following HRGs also relate to audiology, are captured using codes within the admitted patient care or outpatient CDS, and should be reported in Section 3 or Section 4 and not here:

(a) CA38A, Evoked Potential Recording, 19 years and over
(b) CA38B, Evoked Potential Recording, 18 years and under
(c) CA39Z, Fixture for Bone Anchored Hearing Aids
(d) CA40Z, Fitting of Bone Anchored Hearing Aids
(e) CA41Z, Bilateral Cochlear Implants
(f) CA42Z, Unilateral Cochlear Implant.

394. Costs relating to the BAHA and cochlear implant devices, even if currently excluded from national prices, must be included in these HRGs. Costs submitted against cochlear implant HRGs should cover the cost of the external processor (which may be activated at a later time) as well as the cochlear implant itself.

Day care facilities

395. Day care facilities[79] catering for elderly, stroke, mental health (paragraph 324), and

[79] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?show

other patients are included in reference costs. Facilities catering primarily for the long term physically disabled and learning disability patients are excluded, as are all services for these patients.

396. The unit cost is per patient day.

397. Often patients attend these facilities for a number of days each week and the number of attendances per patient will vary due to the different nature of the patient's condition. Generally, the number of places each day is fixed, e.g. 20 patients each day over five days gives 100 patient days, or one patient attending one day per week for 20 weeks gives 20 patient days. A conversion should be made from a part day attendance to a patient day for patients attending for only part of a day, e.g. a morning only attendance equals 0.5 patient days.

398. Any additional costs incurred when an admitted patient attends a day care facility, and their bed is not filled but retained for their later use, should be removed from the total cost of the day care facility and reported as part of the composite cost of that admission. No day care facility activity should be counted for such patients.

Health promotion programmes

399. In 2013-14 we are introducing currencies for health promotion programmes based on classifications in the Data Dictionary[80] that, with the exception of parentcraft, were excluded from reference costs in previous years. Health promotion programmes are delivered to groups rather than individuals and are directed towards particular functions (such as parenthood), conditions (such as obesity), and aspects of behaviour (such as drug misuse). The unit cost is the cost per group session. The currencies are:

(a) Contraception and sexual health
(b) Parentcraft
(c) Stop smoking education programme
(d) Substance misuse
(e) Weight management
(f) Other.

Intermediate care services

400. Intermediate care[81] is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

401. Intermediate care has been described as a function rather than a discrete service,

nav=1

[80] http://www.datadictionary.nhs.uk/data_dictionary/attributes/h/health_promotion_programme_aim_de.asp?shownav=1

[81] Intermediate Care – Halfway Home, Updated Guidance for the NHS and Local Authorities, Department of Health (2009)

linking and filling gaps in the local network to support patients through periods of transition, and incorporating a wide range of different services. The services that might contribute to the intermediate care function include:

(a) rapid response teams to prevent avoidable admission to hospital for patients referred from GPs, A&E or other sources, with short-term care and support in their own home
(b) acute care at home from specialist teams, including some treatment such as administration of intravenous antibiotics
(c) residential rehabilitation in a setting such as a residential care home or community hospital, for people who do not need 24-hour consultant-led medical care but need a short period of therapy and rehabilitation, ranging from one to about six weeks
(d) supported discharge in a patient’s own home, with nursing and/or therapeutic support, and home care support and community equipment where necessary, to allow rehabilitation and recovery at home
(e) day rehabilitation for a limited period in a day hospital or day centre, possibly in conjunction with other forms of intermediate care support.

402. In part because of this wide range of services, and the relatively recent development of policy and practice, the reference costs guidance has not been consistent in its treatment of the intermediate care function.

403. Intermediate care itself has been listed alongside NHS continuing healthcare as a service that is excluded from reference costs. £547 million was excluded in 2012-13.

404. Admission prevention (or “step up”) schemes such as community falls and bone health teams, fast response teams, older persons adult liaison and rapid access clinics have also been excluded (£124 million in 2012-13).

405. Conversely, hospital at home and early discharge (or “step down”) services (£31 million in 2012-13), and community rehabilitation teams (£197 million in 2012-13), have been included.

406. Other services that may sometimes relate to the intermediate care function, and have been excluded from reference costs, are nursing and residential care homes and step down beds in residential facilities.

407. We propose beginning to address these inconsistencies by introducing currencies for all intermediate care services offered to adults aged 19 years and over in 2013-14 reference costs. The key client groups for these currencies are older people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospitals or residential or nursing care homes. Other groups may also be included, such as young disabled people managing transition to adulthood. Intermediate care may also be provided for older people with mental health needs, e.g. dementia, but these costs and activity should be included in the mental health care clusters in Section 9 and not here.

408. Intermediate care is provided to patients whose short-term needs can be addressed within a limited period of weeks (although there is no standard time period), as part of their overall care pathway. Care is arranged on the basis of an assessment leading to an intermediate care plan for each individual, with a team member making sure

that it is carried out. All intermediate care plans should include a review at regular intervals within six weeks or less. If care needs to last longer, reviews take place at regular intervals, such as every two weeks. Patients are then discharged to their own home (with or without further support), to hospital, or to residential or nursing home care.

409. A core intermediate care team is likely to include support workers, nurses, physiotherapists, social workers and community psychiatric nurses, and to be led by a senior clinician.

410. The currencies that we are proposing to introduce are:

(a) intermediate care bed based services – unit cost per occupied bed day in a community hospital, residential intermediate care unit, residential or nursing care home
(b) intermediate care community or home based services – unit cost per day.

411. In addition, we propose collecting the number of completed intermediate care plans in the reference costs year as memorandum information. Where a plan results in bed based and community or home based care, it should be split pro rata to the number of days in each setting. For example, a care plan with 7 bed based days and 7 home based days should be recorded as 0.5 against each currency. Given that only completed plans are included, costs and activity relating to incomplete plans should be excluded, consistent with paragraph 37 .

412. At this stage, we are not proposing to introduce currencies for the conditions typically supported by intermediate care, e.g. falls, fractured neck of femur, infection, mobility problems, respiratory problems, or stoke.

413. Some elements of the service should be allocated as overhead costs to completed intermediate care plans: e.g. teams based in A&E department to identify patients for whom an admission could be avoided, or nurses working with ward staff to identify patients who could be discharged to intermediate care.

414. Intermediate care services are typically jointly commissioned and funded by the clinical commissioning group and local authority. Pooled or unified budgets are sometimes excluded from reference costs (Section 15), but trusts are encouraged to identify and include the discrete element of the intermediate care service that is funded and provided by the NHS.

415. NHS continuing healthcare and NHS-funded nursing care, eligibility for which might be considered after a patient has finished a period of intermediate care, remain excluded from reference costs.

Wheelchair services

416. In 2013-14 we are introducing needs based currencies for non-complex wheelchair services covering assessment, equipment, review and repair and maintenance (Table 32), based on a report commissioned by the Department of Health from Deloitte to develop an initial non-mandatory tariff for these services. These currencies do not cover specialised complex wheelchair services commissioned by NHS England, which should be separately reported on the basis of unit cost per

registered user.

Table 32: Wheelchair service currencies

Currency	Unit
Assessment – Low need	Per assessment
Assessment – Medium need	
Assessment – High need - Manual	
Assessment – High need - Powered	
Equipment – Low need	Per chair issued
Equipment – Medium need	
Equipment – High need – Manual	
Equipment – High need – Powered	
Repair and maintenance – All needs - Manual	Per registered user
Repair and maintenance – All needs - Powered	
Review – All needs	Per review
Review substantial accessory – All needs	Per item

417. The currencies themselves make no distinction between adults and children. However, in order to understand the cost differentials between adults and children we have included a split between adults (aged 19 and over) and children (up to and including 18 years).

Assessment currencies

418. The assessment currencies are stratified according to level of need on the following basis:

    (a) Low need – a limited allocation of clinical time, reflecting the expectation that the assessment needs of the majority of users falling into this category can be met through telephone triage, or review of referral materials provided by a competent referrer
    (b) Medium and high need (manual chair) – a higher allocation of clinical time to conduct a comprehensive assessment for the prescription of a manual chair, including an allocation of time to both therapist and rehabilitation engineer
    (c) High need (power chair) – a longer assessment to allow a comprehensive assessment for the prescription of a power chair, including an allocation of time for both therapist and rehabilitation engineer
    (d) Review – a separate currency to incentivise clinical reviews for service users. Where a full assessment for the new equipment is deemed, as identified by the review, would require further assessment and provision. These additional elements would need to be costed through the other currencies.

419. The allocation of costs against these currencies includes provision for prescription of equipment. However, clinical and rehabilitation engineering time associated with delivery and handover of a wheelchair is included in the equipment currencies detailed below due to the potential for different service providers to complete these tasks.

420. The unit cost for assessment currencies is per episode of care.

Equipment currencies

421. 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. Users deemed to have a higher level of need on any element of the equipment package would be reimbursed at that higher level of provision for the equipment package as a whole, e.g. a basic chair with an enhanced pressure-relieving cushion would be costed at the medium level of complexity.

422. Equipment currencies are stratified by the following levels of need:

(a) Low
(b) Medium
(c) High (manual)
(d) High (power).

423. In addition, a currency is included for the provision of substantive additional accessories, e.g. replacement seat back, or upgrades to cushions as part of a review assessment. It is not intended that this currency be used to inflate costs associated with the provision of new equipment.

424. Allocation of costs to these currencies should be made on the basis of average costs, reflective of the level of need, for appropriate

(a) Chair
(b) Cushioning
(c) Accessories
(d) Occupational therapy technician or rehabilitation engineering time to perform modifications to the chair and fitting of accessories
(e) Clinical time associated with checking of modifications and handover of equipment.

425. The unit of cost for the equipment currencies is per chair issued.

Repair and maintenance currencies

426. The relative complexity of manual and power chairs, different cost base for parts and the need for annual service or planned preventative maintenance, result in the need for different currencies for each type of equipment. Allocation of costs to these currencies should be made on the following basis:

(a) Parts and labour for repair of wheelchairs
(b) Delivery or collection of chairs to or from users
(c) Costs associated with scrapping chairs at the end of their useful lifecycle
(d) Annual planned preventative maintenance for power chair users.

427. The unit cost for the repair and maintenance currencies is per registered user per year.

Section 11: Ambulance services

Introduction

428. This section covers emergency and urgent services provided by ambulance service trusts and the Isle of Wight NHS Trust.

Currencies

429. The currencies were developed and agreed with ambulance trusts and commissioners to support the contracting and payment of emergency and urgent ambulance services from April 2012. We plan to align their definitions with the Ambulance Quality Indicators[82]. The four currencies are:

(a) calls
(b) hear and treat or refer
(c) see and treat or refer
(d) see and treat and convey.

Calls

430. The activity measure is the number of emergency and urgent calls presented to switchboard and answered.

431. 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, NHS Direct, other third parties). Amend 111 calls are excluded from reference costs.

432. Include hoax calls, duplicate or 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.

433. Exclude calls abandoned before answered, PTS requests, calls under any private or non-NHS contract.

434. The unit cost is the cost per call.

Hear and treat or refer

435. The activity measure is the number of patients, following emergency or urgent calls, whose issue was resolved by providing clinical advice by telephone or referral to a third party.

436. Include patients whose call is resolved without despatching a vehicle, or where a vehicle is despatched but is called off from attending the scene before arrival – either by providing advice through a clinical decision support system or by a healthcare

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

professional providing clinical advice or by transferring the call to a third party healthcare provider.

437. An ambulance trust healthcare professional does not arrive on scene.

438. The unit cost is the cost per patient.

See and treat or refer

439. The activity measure is the number of incidents, following emergency or urgent calls, resolved with the patient being treated and discharged from ambulance responsibility on scene. There is no conveyance of any patient.

440. Include incidents where ambulance trust healthcare professionals on scene refer (but do not convey) the patient to any alternative care pathway or provider.

441. Include incidents where, upon arrival at scene, ambulance trust professionals are unable to locate a patient or incident.

442. Include incidents despatched by third parties (such as 111, NHS Direct or other emergency services) directly accessing the ambulance control despatch system.

443. The unit cost is the cost per incident.

See and treat and convey

444. The activity measure is the number of incidents, following emergency or urgent calls, where at least one patient is conveyed by ambulance to an alternative healthcare provider.

445. Alternative healthcare provider includes any other provider who can accept ambulance patients, such as A&E, MIU, walk-in centre, major trauma centre, independent provider etc.

446. Include incidents despatched by third parties (such as 111, NHS Direct or other emergency services) directly accessing the ambulance control despatch system.

447. Exclude PTS and other private or non-NHS contracts.

448. The unit cost is the cost per incident.

Section 12: Cystic fibrosis

Introduction

449. This section covers the cystic fibrosis year of care currency that adult and paediatric cystic fibrosis centres[83], and other providers where network care arrangements are in place, should use to report reference costs.

450. The Grouper generates HRGs for cystic fibrosis (DZ13*, PA13*) that we will remove from the reference costs workbook – their costs should be included in the year of care currencies.

451. To support quality improvements in these year of care costs, we recommend that trusts should:

(a) calculate costs against the 2013 calendar year bands issued in February 2014 by the Cystic Fibrosis Trust, with no further local adjustment
(b) ensure the data from network care providers conforms with this banding data before submission
(c) ensure that all patients are allocated to the appropriate specialist and network care reporting lines
(d) separate new patients from normal band 2a patients using the reporting lines provided.

Year of care currencies

452. Under the year of care currency model, each patient is allocated to one of seven bands derived from clinical information including cystic fibrosis complications and drug requirements, each of which describes an increasingly complex year of care. The bands are described in the SSNDS Definition No. 10 Cystic Fibrosis Services (all ages) (3rd Edition)[84].

453. The Cystic Fibrosis Trust[85] produces the bandings based on data returned by both specialist centres and network care providers to its national database, the UK Cystic Fibrosis Registry. Trusts should access their banding data from the Registry through their lead clinician.

454. Allocations to bands are based on data from the calendar year before the next financial year and are issued each February. The 2013 calendar year bands issued in February 2014 by the Cystic Fibrosis Trust should be used for 2013-14 reference costs.

455. Because cystic fibrosis is a long term condition there is relatively little movement between bands from one year to another, rather there is a steady progression of disease severity over several years. There will be no movement of patients between bands during any one financial year.

[83] http://www.cftrust.org.uk/aboutcf/cfcare/ukcfcentres/
[84] http://www.specialisedservices.nhs.uk/doc/cystic-fibrosis-services-all-ages
[85] http://www.cftrust.org.uk/

456. The currencies themselves make no distinction between adults and children. However, in order to understand the cost differentials we have retained a split in reference costs between adults (defined here as patients aged 17 and over) and children (defined as patients aged 16 and under).

Part year of care

457. There are likely to be increases and decreases in the numbers of patients in each band in any one centre during the financial year. This will be due to births, newly diagnosed patients, transition from children's to adult services, natural patient movement from one location to another, transplantation and deaths. Because costing will be done on the basis of bands issued in February, we expect that this will have minimal impact. However, to ensure the bands only show full year of care costs, and to maintain the principle of full absorption costing, we have provided separate reporting lines for part year of care patients.

458. Newly diagnosed patients and new births will be banded as 2A, which recognises the additional costs associated with diagnosis and treatment of a new patient. These patients will be revised by the Cystic Fibrosis Trust when the bandings are reissued for the following year.

459. Clinical transition from a children's to an adult service or transfer to another centre may take place over a period of time. For the purposes of payment the two centres must agree a date at which responsibility for care will transfer, and this will inform the reporting of part year costs.

460. In some cases, such as where young people are away at university or patients need care whilst on holiday, there may not be a formal transfer of care as an individual may not wish or need to have their care transferred to a new centre. Should treatment be required away from the centre responsible for their care, the responsible centre will be expected to cost this under a provider-to-provider agreement (paragraph 508).

Network care

461. Network care is a recognised model for paediatric care, where children may not receive all their care at a specialist centre and may receive some care at other local hospitals or clinics under network care arrangements. We have therefore split the currencies for children between specialist centres and network care providers.

462. Specialist centres with network care arrangements with other providers should:

(a) return costs and activity for children for whom they provide 100% of cystic fibrosis care on the 'Cystic fibrosis band [1/1A/2/2A/3/4/5] children 16 years and under specialist provider' lines of the reference costs workbook
(b) return costs and activity for children for whom they provide less than 100% of cystic fibrosis care, because a proportion of the care is undertaken by another provider under a network care arrangement, on the 'Cystic fibrosis band [1/1A/2/2A/3/4/5] children 16 years and under shared care provider' lines of the reference costs workbook
(c) list the relevant shared care providers for children returned under (b) in the

memorandum column.

463. Network care providers with network care arrangements with specialist centres should:

(a) return costs and activity for children for whom they have provided a proportion of the care on the 'Cystic fibrosis band [1/1A/2/2A/3/4/5] children 16 years and under shared care provider' lines of the reference costs workbook
(b) list the relevant specialist centres for children returned under (a) in the memorandum column.

464. Specialist centres will be those from which NHS England commissions cystic fibrosis services.

Costing cystic fibrosis

465. The costs submitted against the bands issued in February 2014 should cover all cystic fibrosis related care for the 2013-14 financial year. This includes:

(a) any admitted patient care episode or outpatient attendance that is for the purpose of cystic fibrosis, regardless of whether it is one of the DZ13* or PD13* HRGs or not, whether delivered at a specialist centre or network care provider. Examples include patients admitted for treatment of exacerbation of chest infection, admitted for medical treatment of cystic fibrosis distal intestinal obstruction syndrome, or admitted with a new diagnosis of cystic fibrosis related diabetes to establish a new insulin regimen. To help identify activity, TFCs for adult cystic fibrosis (TFC 343) and paediatric cystic fibrosis (TFC 264) should be used as described in the Data Dictionary[86]. A primary diagnosis of cystic fibrosis may also be a useful way to identify cystic fibrosis specific care
(b) 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 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 admitted patient care
(d) annual review investigations.

466. The following costs should not be included in the bands:

(a) the high cost, cystic fibrosis specific, inhaled or nebulised drugs Aztreonam lysine, Colistimethate sodium, Dornase alfa, Mannitol and Tobramycin. The total cost of these drugs for all full year of care and part year of care patients should be reported in the excluded services worksheet in the reconciliation statement workbook (paragraph 469). The cost of each of these drugs in each band for full year of care patients, but excluding part year of care patients, should also be separately noted in the outpatient (regardless of setting) columns of the drugs and devices worksheet (paragraph 523). Note that this exclusion differs from

[86] http://www.datadictionary.nhs.uk/web_site_content/supporting_information/main_specialty_and_treatment_function_codes.asp?shownav=1

the usual treatment of high cost drugs without unbundled HRGs described in paragraph 86)

(b) unrelated care which will be assigned to the relevant HRG or TFC, e.g. obstetric care for a pregnant woman with cystic fibrosis, ENT outpatient review for nasal polyps. Cystic fibrosis ICD-10 codes are included in HRG complication and comorbidity lists and recognised in HRG+ output

(c) insertion of gastrostomy devices and insertion of TIVADs are not included in the annual banded tariff. The associated surgical costs should be covered by the relevant separate codes

(d) costs associated with long-term nutritional supplementation via gastrostomy or nasogastric tube feeding, which remain within primary medical services

(e) costs associated with all other chronic non cystic fibrosis specific medication prescribed by GPs and funded from primary medical services, e.g., long-term oral antibiotics, pancreatic enzyme replacement therapy, salt tablets, and vitamin supplements

(f) costs associated with high cost antifungal drugs that generate an unbundled high cost drug HRG

(g) neonates admitted with meconium ileus should be costed against the relevant HRG. Annual banding should not include the period they spent as an admitted patient receiving their initial surgical management

(h) patient transport services.

467. Funding of the named high cost drugs above will be governed by national commissioning policies. Prescription of these drugs will be initiated by the specialist centre. However, should long term usage be required (as in bands 2A to 5), it may be to the greater benefit of the patient if the responsible GP is prepared to continue prescribing. Under these circumstances, and where the prescribing GP has recharged the specialist centre for the actual cost of drugs received, the specialist centre should exclude these in the excluded services worksheet and report them separately in the drugs and devices worksheet as described above.

468. We are aware that there are very small numbers of severely ill band 5 patients with highly variable costs. Some may require continuous intravenous antibiotics but can manage their care at home with the support of the specialist team. Others may require prolonged and continuous intravenous antibiotics and hospitalisation over a period of six months or more. Such costs should nevertheless be included.

Section 13: Services excluded from reference costs

469. Reference costs are intended to capture the costs of all services provided by NHS trusts and NHS foundation trusts, to support national price setting, currency development, and benchmarking.

470. Services are only excluded from reference costs if they meet one or more of the following criteria:

   (a) no national requirement to know costs
   (b) lack of clarity as to the unit that could be costed
   (c) no clear national definitions of a service
   (d) no clearly identifiable national classification or currency
   (e) underlying information flows do not adequately support data capture
   (f) overlaps with social care or other funding.

471. Only services listed in Table 33 may be excluded. The workbook includes additional lines to capture other services which, in exceptional circumstances, we give trusts permission to exclude before the collection. Trusts must only use these lines to record agreed exceptional items, and not to clarify existing exclusions.

472. Trusts wishing to exclude an additional service must first seek permission, providing as much detail as possible about costs, volumes, primary and secondary classification codes, and other trusts known to provide the service. A number of exclusion requests we have previously received relate to nationally commissioned, highly specialised services. Such services should not be excluded. The funding stream used to recover the costs of these services is not a relevant consideration (paragraph 4(e)), and none of the criteria in paragraph 469 apply.

473. The total costs of services excluded should be calculated using total absorption costing, should reflect their entire cost rather than just direct cost, and should be noted on the reconciliation statement.

Table 33: Services excluded from reference costs

Excluded service	Definition or description	Why is the service excluded?
Cystic fibrosis drugs	The high cost, cystic fibrosis specific, inhaled or nebulised drugs Aztreonam lysine, Colistimethate sodium, Dornase alfa, Mannitol and Tobramycin are excluded. The cost of these drugs should also be separately reported by cystic fibrosis banding in the drugs and devices worksheet (paragraph 466).	These drug costs are not part of the mandatory cystic fibrosis year of care currency.
Gait analysis	A diagnostic used to measure abnormalities in walking patterns, assist clinical decisions about treatment (e.g. surgery, therapy and orthotics), and evaluate the outcome of treatment	No suitable currency exists.
Genetic laboratory services	Specialist laboratory services that are nationally commissioned and members of the United Kingdom Genetic Testing Network (UKGTN)[87]. Each laboratory carries out rare genetic tests for a large number of hospitals.	These services are hosted in one provider, providing benefit for the patients of other provider, and there is no patient event to which costs can be allocated. The host provider is fully funded, and there is no recharge to other provider.
Healthy start	Government scheme to improve the health of low-income pregnant women and families on benefits and tax credits[88]	No national requirement to understand the costs.
Home delivery of drugs and supplies: administration and associated costs	Trusts incur costs in delivering drugs, oxygen, blood products or supplies directly to patient's homes, without any associated clinical activity at the time of delivery. On this line, trusts should include the administration and associated costs relating to home delivery of drugs and supplies, including: • costs of enrolling patients and the managing of the home care service • costs of contracting, ordering, invoice matching and payment • nurse support of a non-clinical nature • any other associated administrative costs.	There is currently no national requirement to understand the unit costs of providing this service.

[87] http://www.ukgtn.nhs.uk/gtn/Home
[88] http://www.healthystart.nhs.uk/

Excluded service	Definition or description	Why is the service excluded?
Home delivery of drugs and supplies: drugs, supplies and associated costs	On this line, trusts should include the costs of the: • drugs, including oxygen or blood products • supplies, e.g. continence pads or enteral feeding • delivery of drugs or supplies • any other associated drug or supply costs.	There is currently no national requirement to understand the unit costs of providing this service.
Hospital travel costs scheme	Scheme offering financial help with the cost of travel to and from hospitals and other NHS centres[89]. Note that overnight stays are not part of the HTCS. However, the HTCS guidance states: " Where an overnight stay away from home is unavoidable, either because of the time of the appointment or length of travel required, and the patient is unable to meet the cost of this stay, the expense should be treated as part of treatment costs or met through non-Exchequer funds. This should be discussed with the relevant CCG before the overnight stay occurs." Providers should therefore include overnight stays as an overhead in their reference costs.	Because this scheme makes fixed payments to eligible NHS patients there is no requirement to understand or benchmark provider unit costs.
Intensive care support services	Services providing transport, advice or other services for critical care patients on a regional basis..	These services are hosted in one provider, providing benefit for the patients of other provider, and there is no patient event to which costs can be allocated. The host provider is fully funded, and there is no recharge to other provider.
Learning disability services		Currencies are in development and may be included in reference costs in future.
Local Improvement Finance Trust (LIFT) and Private Finance Initiative (PFI) set up costs	See paragraph 475	These are one-off costs.

[89] https://www.gov.uk/government/publications/healthcare-travel-costs-scheme-instructions-and-guidance-for-the-nhs

Excluded service	Definition or description	Why is the service excluded?
NHS continuing healthcare and NHS-funded nursing care	NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a "primary health need" as set out in guidance[90]. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. It can be provided in any setting including, but not limited to a care home, a hospice or a patient's home. NHS-funded nursing care is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse.	We wish to first test our proposals for intermediate care services in Section 10 before considering NHS continuing healthcare.
Patient transport services (PTS)	Services run by ambulance trusts and other PTS providers offering free transport to and from hospital for people who have a medical need.	There is currently no national requirement to understand the costs of providing these services.
Pooled or unified budgets	As a general principle, costs and activity are excluded for services jointly provided under pooled or unified budget arrangements with agencies outside the NHS such as social services, housing, employment, education (e.g. Sure Start), home equipment loans or community equipment stores (e.g. walking aids, grab rails, commodes). This also includes: • costs relating to advice to non-NHS bodies (e.g. paragraph 369(c)) • vaccination programmes part-funded by GPs or non-NHS providers Where organisations are confident that they can • separately identify a discrete element of the service that is funded by the NHS and • identify the total costs incurred by that service • have accurate and reflective activity data then they are encouraged to include that service.	Services provided by bodies outside the NHS such as local government are outside the scope of reference costs.

[90] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

Excluded service	Definition or description	Why is the service excluded?
Primary medical services	Services provided under a primary medical services contract (General Medical Services (GMS), Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) and Specialist Medical Provider Services (SPMS)). Includes GP provided open access services and GP out of hours services.	Primary medical services are subject to separate funding arrangement and are outside the scope of reference costs.
Prison health services		Availability of activity data has been an issue with prison health services. However, some costs and activity, are included in reference costs (prison health and mental health specialist teams, paragraph 335(h)), and we are interested in exploring whether other costs and activity could be included in future years.
Screening programmes	National screening programmes[91]	Treatment varies – some national screening programmes are excluded and some are included. See Table 34.
Specified services provided by ambulance trusts	The following services or costs are excluded (ambulance trusts only): • Air ambulance service • Chemical biological radiological and nuclear costs • Decontamination units • Emergency bed service • Emergency planning • Hazardous area response teams • Helicopter emergency medical services (part provided by Barts Health NHS Trust) • Logistics or courier transport service e.g. collecting clinical waste • Neonatal transfers (non-ambulance trusts should report the costs of neonatal critical care transportation under HRG XA06Z) • Out of hours services • Patient education • Single point of access telephony services (e.g. 111, NHS direct)	These services are not part of the ambulance service currencies for contracting, and no other suitable currency exists

[91] http://www.screening.nhs.uk/index.php

Excluded service	Definition or description	Why is the service excluded?
Specified services provided by mental health trusts	The following services delivered by mental health trusts: • Acquired brain injury • Neuropsychiatry	No suitable currencies exist
Specified services provided by other named providers	The following services are excluded: • Clinical Toxicology Service - Guy's and St Thomas' NHS Foundation Trust • Fixated threat assessment centre - Barnet, Enfield and Haringey Mental Health NHS Trust • High secure infectious disease units - Royal Free London NHS Foundation Trust and The Newcastle upon Tyne Hospitals NHS Foundation Trust • Low energy proton therapy for ocular oncology - Clatterbridge Centre for Oncology NHS Foundation Trust • National Poisons Information Service and - The Newcastle Upon Tyne Hospitals NHS Foundation Trust • National Artificial Eye Service – Blackpool Teaching Hospitals NHS Foundation Trust No other service by any other provider may be excluded in this category without our permission.	These are unusual services, each provided by one or two named providers, where there is currently no requirement to submit costs for benchmarking or any other purpose.

474. The inclusion or exclusion of national screening programmes varies. Table 34 clarifies the treatment of each programme.

Table 34: UK national screening committee programmes

Programme	Included or excluded
Antenatal and newborn	
NHS Fetal Anomaly Screening Programme	Included in relevant maternity outpatient and admitted patient costs
NHS Infectious Diseases in Pregnancy Screening Programme	Included in relevant maternity outpatient and admitted patient costs
NHS Linked Antenatal and Newborn Sickle Cell and Thalassaemia Screening Programme	Included in relevant maternity outpatient and admitted patient costs. Exception is for the small number of genetic tests that occur, which are excluded and should be funded directly by PCTs[92]
NHS Newborn and Infant Physical Examination Screening Programme	Included in the cost of maternity delivery HRGs or postnatal visits
NHS Newborn Blood Spot Screening Programme	The taking of the sample is included in the cost of maternity delivery HRGs or postnatal visits. Its analysis by regional newborn screening services is excluded from reference costs
NHS Newborn Hearing Screening Programme	Included in audiology services neonatal screening (paragraph 391)
Young person and adult	
NHS Abdominal Aortic Aneurysm Screening Programme	Excluded
National Screening Programme for Diabetic Retinopathy	Included in diabetic retinal screening, which should be reported as a directly accessed diagnostic service against HRG WA20Z
NHS Breast Screening Programme	Excluded
NHS Cervical Screening Programme	Excluded
NHS Bowel Cancer Screening Programme	Excluded
Related programmes[93]	
Health check (vascular risk)	Excluded
Chlamydia screening	Excluded
Prostrate cancer	Excluded

475. Table 35 clarifies the treatment of PFI or LIFT expenditure. As a general principle, PFI or LIFT set up costs include one off revenue costs incurred in setting up a PFI or LIFT scheme from the initial business case stage to financial close. This includes fees (consultancy, legal, financial etc) and other costs such as planning applications. These set up costs should be excluded from reference costs.

Table 35: PFI and LIFT expenditure

Heading	Comment	Treatment of costs in reference costs
Cost of services		Include
Depreciation charges		Include
Dual running costs	For services transferring	Include. Double running costs for all other service reconfigurations etc. are included.
Interest expense		Include. This includes the indexed elements of PFI payments that do not relate to services.

[92] http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_104835
[93] Not approved by the UK national screening committee

Heading	Comment	Treatment of costs in reference costs
Interim services (including pass through costs)	Facilities management costs transferred early	Include
Subleasing income		Include. Income generated from any subleased areas should be deducted from overall PFI costs.
Accelerated depreciation		Exclude. Accelerated depreciation should be excluded.
Advisor fees	External advice provided to the Trust	Exclude. Set up costs (principally fees) incurred by the trust in the development of a PFI scheme can be excluded.
Annual capital expenditure	Such as lifecycle costs	Exclude. The costs of capital items are picked up through depreciation in the same way as all other capital assets.
Demolition costs	These are works undertaken and paid for by the trust outside of the PFI contract	Exclude. If the scheme were to be funded through public capital this is likely to be capital expenditure.
Impairment charge		Exclude. This is consistent with the principle that reference costs reflect ordinary ongoing revenue costs and exclude extraordinary one off costs unless otherwise stated.
Project team	Trust project team	Exclude. Set up costs (principally fees) incurred by the trust in the development of a PFI scheme can be excluded. Please ensure that you can satisfy the auditors that the costs of the project team relate solely to the time spent working on the PFI scheme.
Profit on sale of surplus land or buildings		Exclude.
Repayment of finance lease		Exclude.
Other costs	Other payments not made to PFI provider	Other costs incurred by the trust that are a result of the PFI development but are not payments made to the PFI provider should be treated in the same way as other similar trust costs as directed in this guidance.

Section 14: Reconciliation

Introduction

476. The completion of the reconciliation statement and associated worksheets are an essential part of the reference cost process. These worksheets are:

(a) **reconciliation** – this reconciles each trust's reference cost quantum to the signed annual accounts
(b) **drugs and devices** - a memorandum of high cost drugs and devices, the costs of which must be included against the appropriate HRGs in the reference costs workbook, and separately identified here to inform price setting and other analysis
(c) **survey** – a mandatory survey about PLICS implementation and other questions about the costing process including clinical engagement
(d) **checklist** – the self-assessment quality checklist described in Section 2.

477. It is desirable to complete the reconciliation at the start of the reference costing process. Identifying excluded services, costs (or income) relating to non-patient care activities, and agreeing totals to final accounts will provide confidence that the correct reference cost quantum has been established before costing services.

478. Although each trust will have their own process, the following steps are likely to apply to all:

(a) ensure the financial accounts are closed and the final version of the general ledger is available

(b) obtain the final trial balance or drawdown the general ledger, or both, and ensure they agree, at detailed account code level

(c) allocate the lines on the trial balance/download to the lines on the reconciliation worksheet. At this stage, it may be possible to extract data for the drugs and devices worksheet, and for allowable income

(d) check the figures obtained in the step above agree to the final audited accounts spreadsheets (TRUs for NHS trusts, FTCs for NHS foundation trusts). It may be necessary to ask colleagues in financial accounts for this information

(e) complete the reconciliation worksheet to the total costs in **Line 28** and ensure this agrees to the trial balance/download

(f) check the data against last years to identify any material or unexpected variations, and investigate if needed

(g) import this quantum into the costing system

(h) identify excluded services from the outputs of the costing system and add these to the appropriate lines in the reconciliation statement

(i) ensure the total reference cost quantum in the completed reference costs workbook agrees to the total reference cost submission quantum in **Line 32** on the reconciliation worksheet

(j) complete the drugs and devices worksheet

(k) final check of the reconciliation statement against last years to identify any material or unexpected variations, and investigate if needed.

Non-patient care activities

479. Education and training, research and development, and commercial or other activities not primarily related to providing care to NHS patients are funded from sources other than contracts with NHS commissioners, are not reimbursed through national prices, and therefore should be excluded from reference costs.

480. To date, our approach has been to require trusts to net off income associated with these funding streams from their operating expenses before calculating reference costs. This assumes that income exactly matches the costs. However, if income is more than costs, this has the impact of lowering reference costs (and national prices) below the real cost of providing patient care. Similarly, if income is less than costs, this has the impact of raising reference costs (and national prices) above the real cost of providing patient care.

481. We are therefore working towards a position where the cost of providing the service, rather than the income from the service, is excluded from reference costs. Trusts should refer to Standard 7 of the *HFMA Clinical Costing Standards* for guidelines on separating the costs of non-patient care activities from the costs of providing patient care.

482. The simplest of revenue streams not relating to NHS patient care are those from private and other non-NHS patients. Trusts should exclude the costs, rather than net off the income, for these patients. The corresponding income is available in the accounts and there is no need to record this as memorandum information in 2013-14.

483. Progress on costing education and training is set out in paragraph 10. Trusts should continue to net off income for education and training in 2013-14, but also estimate the costs as a memorandum on the reconciliation statement. Additional guidance is available on HEE's website[94].

484. We are interested in exploring whether it would be feasible to ask trusts to exclude research and development costs (relating only to costs that end when the research ends, and not to excess treatment costs – see paragraph 495(c)) in 2013-14.

Question 8: Would you be able to exclude costs rather than net off income relating to research and development in 2013-14?

485. All remaining income received from commercial or other non-patient care activities should continue to be netted off in 2013-14. The allowable income should be

[94] http://hee.nhs.uk/work-programmes/resources/costing-education-and-training/

matched to the service where the income was generated, offsetting the cost of providing the service.

Reconciliation worksheet

486. There is a single reconciliation worksheet for NHS trusts and NHS foundation trusts, completed in £ not in £ thousands.

487. This worksheet reconciles the data recorded in the audited financial statements to the total reference cost quantum. References to lines in the TRUs/FTCs are included where applicable.

488. Trusts obtaining foundation trust status part way through a financial year must include the total of their TRUs and FTCs in order to balance back to their total reference cost quantum. **Line 23 Other gains and losses** has been added to the FTC statement so part year foundation trusts do not need to recalculate the TRU figures to fit the FTC layout. Where there are other presentational differences, e.g. finance costs unwinding of discount, there is no need to restate the TRUs to fit the FTC description, but all costs must be included.

489. The worksheet starts with the total operating expenses reported in the financial statements. There are then a number of adjustments to remove expenditure that is not included in the calculation of reference costs, or to deduct income that should be netted off. Trusts must ensure there is no double counting or double netting off.

490. Net gain or loss on transfer by absorption is not included when calculating reference costs and therefore has no line on the worksheets.

491. **Line 1 Operating expenses** is the starting point to ensure all costs are included in quantum.

492. **Line 2 Less cost of non-NHS private patients** – deduct the costs of providing care to private patients

493. **Line 3 Less cost of non-NHS overseas patients (non-reciprocal)** – deduct the costs of providing care to overseas visitors to the UK who are not exempt from charge under the NHS (Charges to Overseas Visitors) Regulations 2011. This includes most irregular migrants, visitors from a country that the UK does not have a reciprocal agreement with, and some UK citizens residing overseas. Do not deduct the costs of overseas patients (reciprocal)[95]. Their care is commissioned via the CCG and should be included in reference costs as though they were registered or resident in England.

494. **Line 4 Less cost of other non-NHS patients** – deduct the costs of providing care to other non-NHS patients, including:

    (a) armed forces personnel - funded by the Ministry of Defence (MoD) where the requirement varies from the standard NHS pathways in either the treatment

[95] Including patients from the Isle of Man and Jersey (but not other Channel Islands), with whom the UK Government has reciprocal healthcare agreements

requested or management requirements (e.g. fast-track care or non-standard treatment), and identified by the code XMD rather than the PCT code for data submission purposes. Non-standard care arrangements are normally the subject of specific MoD contracts or by prior agreement with the MoD referrer[96]

(b) patients from the devolved administrations (Scotland, Wales and Northern Ireland) - parliament votes the NHS budget based on the requirements of NHS patients in England i.e. those resident in England and legally entitled to NHS care.

495. **Line 5 Less other operating income** – excluding costs rather than netting off income for other funding streams such as education and training, and research, will take time. Therefore, deduct income for the following funding streams, the sum of which must equal other operating income in the relevant line of the financial statements for NHS trusts (TRU01) or NHS foundation trusts (6. Op Inc (type)):

(a) **Line 5a non-salaried education and training costs**

(b) **Line 5b salaried education and training costs**

(c) **Line 5c research and development**, which comprises several funding streams. For reference costs, only research and development income relating to costs that end when the research ends should be deducted here. The following funding streams are allowable income:

(i) research - research grant funding, to pay for the costs of the R&D itself (e.g. writing the research paper), received from the Department of Health (including the National Institute for Health Research (NIHR)), other government departments, charities, and the Medical Research Council (MRC) which includes funding for Biomedical Research Centres, Biomedical Research Units and Collaborations for Leadership in Applied Health Research and Care (CLARHC)

(ii) NHS support - funding from the Department of Health (NIHR) to cover additional patient care costs associated with the research (e.g. extra blood tests, extra nursing time) that end when the research ends

(iii) flexibility and sustainability funding - funding from the Department of Health mainly to support NIHR faculty and associated workforce.

Other research and development funding streams relate to patient care costs that continue after the research ends. These are not allowable income and must not be deducted from the quantum:

(iv) treatment costs including excess treatment costs – funding from normal commissioning arrangements to cover patient care costs associated with the research that continue to be incurred after the research ends if the service in question were to continue

(v) subventions - exceptional funding from the Department to contribute to the cost of very expensive excess treatment costs.

NHS England are reviewing how excess treatment costs might be funded

[96] https://www.gov.uk/government/publications/health-services-for-the-armed-forces-and-veterans

differently in the future. This could have implications for the future reporting of these costs in reference costs.

(d) **Line 5e other income from non-patient care activities**. Income from other non-patient care activities, such as commercial income (e.g. car parking, hospital shop leases), or charitable contributions to expenditure, should be netted off operating costs. Where the income relates to services excluded from reference costs, care must be taken to ensure it is not netted off. There are no costs in the submission to which this income can be matched.

496. **Line 6 Add not allowable income**. Income that cannot be netted off when calculating reference costs, because it relates to patient care activities, must be added back. Examples include CQUIN, targeted funding that relates to patient care, the injury cost recovery scheme, and transitional relief provided to offset exceptional costs (e.g. PFI schemes).

497. **Line 7 Less cost of centrally funded awards under the clinical excellence awards scheme**. Only centrally funded awards under the clinical excellence awards scheme (levels 9 to 12, or distinction award levels B, A and A+ under the old scheme) should be netted off. Internally funded awards (levels 1 to 9, or discretionary points levels 1 to 8 under the old scheme) should not be netted off. Where centrally funded and locally funded awards are included in **Line 5e Other operating income** the amount must be added back there in order to be deducted here, to avoid double netting off.

498. **Line 8 Less funds received for foundation trust application**. Where these are included in **Line 5 Other operating income** the amount must be added back there in order to be deducted here.

499. **Line 9 Less PFI or LIFT exclusions**. The set up costs of PFI or LIFT schemes (Table 35) should be recorded on the **services excluded** worksheet. Any profit/loss from the sale of non-current assets in a PFI or LIFT deal should also be included here to net off the gain or loss. This would be recorded in income/ expenditure for foundation trusts or other gains and losses in NHS trusts.

500. **Line 10 Less impairments**. Impairments charged through the Statement of Comprehensive Income are not included in reference costs and must be removed. These should be split between:

(a) **Line 10a New build**
(b) **Line 10b Other**.

501. **Line 11 Add reversal of impairments**. Conversely, the reversal of an impairment must be added back. These should be split between:

(a) **Line 11a New build**
(b) **Line 11b Other**.

502. **Line 12 Less capital cost of donated/government granted assets and Line 13 Add donations/government grants received to fund non current assets**. Costs and income associated with donated/government granted non-current assets must be removed. Income received in year is added back (as this will have been deducted

in **Line 5**), and any charges to expenditure such as depreciation are deducted (these will be included in **Line 1**). Take care not to remove impairments, which will have already been deducted in **Line 10 Less impairments**. The income may be actual cash donated to purchase an asset or the asset value where an asset has been donated; the treatment here will be the same.

503. Following a change to the interpretation of accounting standards, the treatment of the credit entry relating to donated assets is no longer held in reserves and used to offset charges to expenditure. The funding element is now recognised as income in year as required by IAS 20 as interpreted by the HM Treasury Financial Reporting Manual.

504. In the year when the asset is received, the trust will have income equal to the value of the asset and a much smaller depreciation charge to expenditure. To prevent any instability in reference costs quantum caused by this large net income in the year of receipt, followed by years of increased costs (i.e. the depreciation charge etc), all income and expenditure relating to donated assets must be excluded from reference costs.

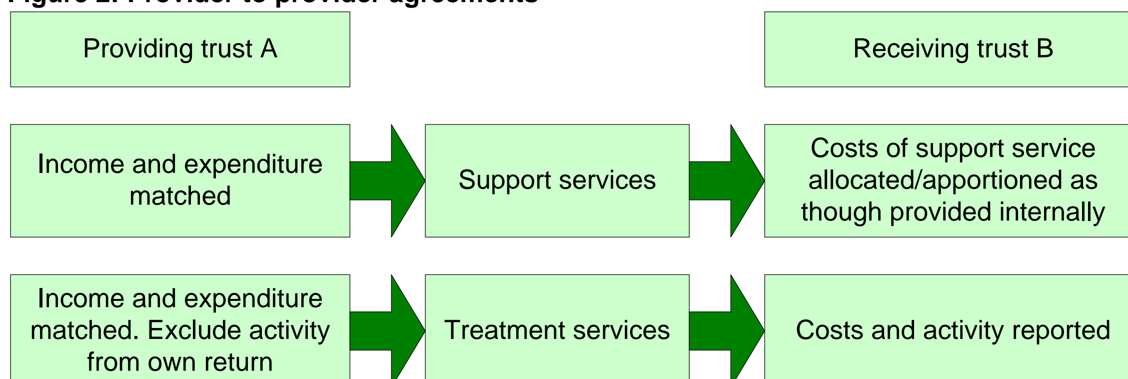
505. This will bring the treatment in line with previous years where the income released from reserves would be equal to the depreciation etc charged and so have a nil effect on reference costs. Impairments will not be an issue as these are not included in reference costs. This change relates equally to government granted assets.

506. **Lines 14 to 19** are blank rows that have been left for trusts to add adjustments that have not been included in the reconciliation. Full details of the adjustment must be provided.

507. **Line 20 Total net operating expenditure** is the sum of **Lines 1 to 19**.

508. **Line 21 Less adjustment for provider-to-provider agreements.** Where there are provider-to-provider agreements for support services (e.g. an administration service, or a service where a trust pays for expenditure on behalf of another trust and is then reimbursed) or treatment services, the costs and associated income should be treated as in Figure 2.

Figure 2: Provider to provider agreements



509. The providing trust (A in Figure 2) in these agreements should:

(a) for support services - record both expenditure and income, which should be matched in line with the costing principles, resulting in a nil net cost. The income from providing the service would be posted to other operating income

and so will already have been netted off expenditure in **Line 5e**

(b) for treatment services – follow the same approach as for support services. Where treatment has been provided to a non-NHS patient, no adjustment will be needed here because the income will already have been deducted in **Lines 2 to 4.** Where the treatment is provided to an NHS patient in another NHS trust then the income will need to be deducted on **Line 21**. Any activity should be excluded from the reference costs workbook. Thus, the matching principle of activity and cost is maintained as the costs are offset by the income and the activity is not double counted across the NHS as a whole.

510. The receiving trust (B) should:

(a) for support services - include the cost paid to the providing trust in its own reference costs, allocated and apportioned on a consistent basis, as if it had provided the service itself. There should be no need for an adjustment in **Line 21**

(b) for treatment services – follow the same approach as for support services, recording both the costs and activity in its reference costs return.

511. **Line 22 Subtotal** is the sum of **Lines 20 and 21**.

512. The net operating cost is then adjusted for the non-operating costs/income lines as reported in the financial accounts.

513. **Line 23 Add other gains and losses**, for NHS trusts only or foundation trusts obtaining foundation trust status in year, for the part of the year they were an NHS trust. This will be mainly profit/loss on disposal of non current assets, which is included in expenditure or other income in foundation trust accounts and therefore does not need to be adjusted. Profit/loss on disposal of non current assets must be included in the reference cost quantum, with the exception of those in a new PFI or LIFT scheme (Table 35), or those arising through transfer of donations (paragraph 34(c)).

514. **Line 24 Less investment revenue or finance income** is interest received.

515. **Line 25 Add finance costs or finance expenses** is interest payable and other costs associated with financing. In NHS trusts, it will also include unwinding of discount on provisions.

516. **Line 26 Add PDC dividends payable** is the PDC payables figure from the Statement of Comprehensive Income, not the cash flow figure.

517. **Line 27 Add finance expenses - unwinding of discount** applies to NHS foundation trusts only and is the cost of the unwinding of discounts on provisions. In NHS trusts it is included in **Line 25**.

518. **Line 28 Total costs** is the sum of **Lines 22 to 27**.

519. **Line 29 Total cost of services excluded from reference costs collection** the sum cost of the excluded services listed in Section 13.

520. **Line 30 Less total cost of services sub-contracted out to non-NHS bodies**. The

total cost to the trust of sub-contracting out services to the independent sector. Include the fully absorbed cost wherever possible. For example, a trust might have an arrangement with their consultants to carry out private work on-site, paid for at a proportion of the tariff price. The cost should include not only the agreed price, but also the overhead costs of the consultants using NHS theatres, consumables etc. in the course of their private work.

521. **Line 31 Add cost of services sub-contracted out to NHS bodies included within reference costs**. Applies only to mental health care clusters and ambulance trusts.

522. **Line 32 Total reference cost submission quantum** is the sum of **Lines 28 to 31** and must agree to within +/- 1% of the main reference cost submission. This will be validated in Unify2.

Drugs and devices

523. This worksheet provides a memorandum of high cost drugs and devices, the costs of which should have been included against the appropriate currencies in the reference costs workbook (with the exception of cystic fibrosis specific drugs, which should have been excluded, and total costs noted on the services excluded worksheet), and separately identified here for further analysis.

524. The data may be used to adjust national prices to reflect the exclusion of some high cost drugs and devices. It is necessary to make these adjustments outside reference costs as the drugs and devices that are unbundled and/or included in national prices may change during the lag between collecting reference costs and setting prices.

525. There is the facility to add additional lines, e.g. for other high cost renal drugs in addition to those named.

526. The National Casemix Office also uses the data when assessing HRG design.

Survey

527. Table 36 contains details of the mandatory survey to collect information about PLICS implementation and use, levels of clinical and financial engagement, and other information to inform national policy making.

Table 36: Reference costs survey

	All organisations	
Q1	What is the status of patient level information and costing systems (PLICS) in your organisation?	• Implemented[97] • Implementing[98] • Planning • Not planning
Q2	How many whole-time equivalent (WTE) staff[99] are engaged in running your costing system and producing cost information:	

[97] IT system purchased, installed and being used to cost at least some services. Where the trust has a PLICS system, but are in the process of updating or replacing it, they should still consider themselves as having implemented PLICS.
[98] IT system is in the process of being purchased and installed.

Q2a	• Finance staff?	[number of WTEs]
Q2b	• Information staff?	[number of WTEs]
Q2c	• Other staff?	[number of WTEs]
Q3	What is the resource commitment (in number of working days) of collating and submitting the annual reference costs return[100] by the following occupational groups:	
Q3a	• Finance staff?	[insert number of days]
Q3b	• Information staff?	[insert number of days]
Q3c	• Senior managers?	[insert number of days]
Q4	What is the level of clinical and financial engagement in your organisation?[101]	• Level 1 • Level 2 • Level 3 • Level 4
Q5	Who is the supplier of your PLICS?	• Allocate • Ardentia • Belvan • Bellis-Jones Hill / Prodacapo • CACI/BPlan • Civica • Costflex • Healthcost • Internally provided • Powerhealth • Other supplier - please specify in Q27 • Not yet chosen • N/A – not planning to implement PLICS

	Implemented: organisations which have implemented PLICS only	
Q5	How often are you producing and reporting patient level cost information?	• Monthly • Bimonthly • Quarterly • Annually • Not reporting • Other – please specify in Q26
Q6	Did you use PLICS to support your reference costs return?	• Yes/No
Q7	If you answered yes to Q5, which service areas in your reference costs return were supported by PLICS?	
Q7a	All services	• Yes/No
Q7b	Admitted patient care	• Yes/No

[99] Disregard time spent on other activities, e.g. 2 WTEs spending 60% of their time running the system should be reported as 2.0 not 1.2.

[100] Include all resource commitments associated with the reference costs return, including reading guidance, gathering and preparing data, assurance etc. Exclude all resource commitments associated with running the costing system and producing cost information for internal use.

[101] This refers to the levels of clinical and financial engagement across the whole organisation and not solely in respect of reference costs. The expectation is that finance professionals should engage with clinicians to reach an agreed level rating for the organisation, rather than finance departments establishing the level of engagement in isolation. *Effective Clinical and Financial Engagement: A Best Practice Guide to the NHS (2013)*, available at https://www.gov.uk/government/publications/nhs-clinical-and-financial-engagement-best-practice, includes a self-assessment tool to support trusts in making an objective assessment of their level of engagement, characteristics and behaviours of the top performing organisations, and examples of best practice.

Q7c	Outpatient services	• Yes/No
Q7d	Emergency medicine	• Yes/No
Q7e	Chemotherapy	• Yes/No
Q7f	Critical care	• Yes/No
Q7g	Diagnostic imaging	• Yes/No
Q7h	High cost drugs	• Yes/No
Q7i	Radiotherapy	• Yes/No
Q7j	Rehabilitation	• Yes/No
Q7k	Specialist palliative care	• Yes/No
Q7l	Renal dialysis	• Yes/No
Q7m	Direct access services	• Yes/No
Q7n	Mental health services	• Yes/No
Q7o	Community services	• Yes/No
Q7p	Ambulance services	• Yes/No
Q7q	Cystic fibrosis	• Yes/No
Q8	If you answered no to Q7, is there a particular reason for this?	• System not fully developed and tested • Differences in reference costs and PLICS methodology • Data quality issues • Other - please specify in Q27
Q9	Did you use the HFMA clinical costing standards as part of your PLICS implementation?	• Fully • Partially • Not at all
Q10	If you did not use the HFMA clinical costing standards as part of your implementation, have you subsequently reviewed your system against the standards?	• Yes/No
Q11	Did you use the HFMA clinical costing standards when producing your reference costs?	• Yes/No
Q12	If you answered no to Q12, why are you not using the HFMA clinical costing standards?	• Our PLICS does not support them • We were not aware of them • Other - please specify in Q27
Q13	Have you used the materiality and quality score (MAQS) as detailed in the HFMA clinical costing standards?	• Yes/No
Q14	When was your PLICS implemented?	• Before 2006 • [Year 2006 to 2014]

	Implementing: organisations which are currently implementing PLICS only	
Q15	What stage of implementation are you at?	• Completed and improving accuracy • Dual running with existing costing system • Supplier chosen
Q16	What is your timescale for completing PLICS implementation?	• Within 1 year • 1-2 years • 2-3 years • 3 years +
Q17	How involved have clinicians been in implementing PLICS?	• Level 1 • Level 2 • Level 3 • Level 4
Q18	Are you using the HFMA clinical costing standards as part of your PLICS implementation?	• Fully • Partially • Not at all

Q19	If you are not using the HFMA clinical costing standards why is this?	• Our PLICS does not support them • We were not aware of them • Other - please specify in Q27

	Planning: organisations which are planning to implement PLICS only	
Q20	What is your timescale for completing PLICS implementation?	• Within 1 year • 1-2 years • 2-3 years • 3 years +

•

	No plans: organisations which are not planning to implement PLICS only	
Q21	If you not planning to implement PLICS, what are the main reasons why not?	• Financial cost of system • Lack of staff resource • Focusing on SLR • Not convinced of benefits to our organisation • Implementing new information systems • On-going strategic review of benefits • Future of organisation is uncertain

	All organisations	
Q22	Do you have any other comments?	[Free text]

Annex A: Submission deadlines

14 July 2014
2GETHER NHS FOUNDATION TRUST
5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
AIREDALE NHS FOUNDATION TRUST
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST
ASHFORD AND ST. PETER'S HOSPITALS NHS FOUNDATION TRUST
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST
BARNET AND CHASE FARM HOSPITALS NHS TRUST
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
BARTS HEALTH NHS TRUST
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
BEDFORD HOSPITAL NHS TRUST
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST
BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST
BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST
BOLTON NHS FOUNDATION TRUST
BRADFORD DISTRICT CARE TRUST
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST
BURTON HOSPITALS NHS FOUNDATION TRUST
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST
CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST
CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST
CROYDON HEALTH SERVICES NHS TRUST
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST
DARTFORD AND GRAVESHAM NHS TRUST
DERBY HOSPITALS NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST
DEVON PARTNERSHIP NHS TRUST
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST

15 July 2014
EALING HOSPITAL NHS TRUST
EAST AND NORTH HERTFORDSHIRE NHS TRUST
EAST CHESHIRE NHS TRUST
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
EAST LANCASHIRE HOSPITALS NHS TRUST
EAST LONDON NHS FOUNDATION TRUST
EAST MIDLANDS AMBULANCE SERVICE NHS TRUST
EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST
EAST SUSSEX HEALTHCARE NHS TRUST
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST
FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST
GATESHEAD HEALTH NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST
HARROGATE AND DISTRICT NHS FOUNDATION TRUST
HEART OF ENGLAND NHS FOUNDATION TRUST
HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST
HERTFORDSHIRE COMMUNITY NHS TRUST
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
HINCHINGBROOKE HEALTH CARE NHS TRUST
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
HUMBER NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
IPSWICH HOSPITAL NHS TRUST
ISLE OF WIGHT NHS TRUST
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST
KENT COMMUNITY HEALTH NHS TRUST
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
KINGSTON HOSPITAL NHS FOUNDATION TRUST
LANCASHIRE CARE NHS FOUNDATION TRUST
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST
LEEDS COMMUNITY HEALTHCARE NHS TRUST
LEEDS TEACHING HOSPITALS NHS TRUST
LEICESTERSHIRE PARTNERSHIP NHS TRUST
LEWISHAM HEALTHCARE NHS TRUST
LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST
LIVERPOOL COMMUNITY HEALTH NHS TRUST
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
LONDON AMBULANCE SERVICE NHS TRUST
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST
MEDWAY NHS FOUNDATION TRUST
MERSEY CARE NHS TRUST
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
MID ESSEX HOSPITAL SERVICES NHS TRUST
MID STAFFORDSHIRE NHS FOUNDATION TRUST
MID YORKSHIRE HOSPITALS NHS TRUST
MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

16 July 2014
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST
NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST
NORTH BRISTOL NHS TRUST
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST
NORTH EAST LONDON NHS FOUNDATION TRUST
NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST
NORTH WEST AMBULANCE SERVICE NHS TRUST
NORTH WEST LONDON HOSPITALS NHS TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST
NORTHERN DEVON HEALTHCARE NHS TRUST
NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS FOUNDATION TRUST
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
NOTTINGHAMSHIRE HEALTHCARE NHS TRUST
OXFORD HEALTH NHS FOUNDATION TRUST
OXFORD UNIVERSITY HOSPITALS NHS TRUST
OXLEAS NHS FOUNDATION TRUST
PAPWORTH HOSPITAL NHS FOUNDATION TRUST
PENNINE ACUTE HOSPITALS NHS TRUST
PENNINE CARE NHS FOUNDATION TRUST
PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST
PLYMOUTH HOSPITALS NHS TRUST
POOLE HOSPITAL NHS FOUNDATION TRUST
PORTSMOUTH HOSPITALS NHS TRUST
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
ROYAL BERKSHIRE NHS FOUNDATION TRUST
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST
ROYAL CORNWALL HOSPITALS NHS TRUST
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST
ROYAL FREE LONDON NHS FOUNDATION TRUST
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST
ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST
ROYAL UNITED HOSPITAL BATH NHS TRUST
SALFORD ROYAL NHS FOUNDATION TRUST
SALISBURY NHS FOUNDATION TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
SHROPSHIRE COMMUNITY HEALTH NHS TRUST
SOLENT NHS TRUST
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST
SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST
SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST
SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
SOUTH LONDON HEALTHCARE NHS TRUST
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST

SOUTH TYNESIDE NHS FOUNDATION TRUST
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST
SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
SOUTHERN HEALTH NHS FOUNDATION TRUST
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST
ST GEORGE'S HEALTHCARE NHS TRUST
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST
STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST
STOCKPORT NHS FOUNDATION TRUST
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST
SURREY AND SUSSEX HEALTHCARE NHS TRUST
SUSSEX COMMUNITY NHS TRUST
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST

17 July 2014
TAMESIDE HOSPITAL NHS FOUNDATION TRUST
TAUNTON AND SOMERSET NHS FOUNDATION TRUST
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST
THE CHRISTIE NHS FOUNDATION TRUST
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE GLOUCESTERSHIRE CARE SERVICES NATIONAL HEALTH SERVICE TRUST
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROTHERHAM NHS FOUNDATION TRUST
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST
THE ROYAL MARSDEN NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE WALTON CENTRE NHS FOUNDATION TRUST
THE WHITTINGTON HOSPITAL NHS TRUST
TORBAY AND SOUTHERN DEVON HEALTH AND CARE NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST
UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
WALSALL HEALTHCARE NHS TRUST
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST
WEST HERTFORDSHIRE HOSPITALS NHS TRUST
WEST LONDON MENTAL HEALTH NHS TRUST
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST
WEST SUFFOLK NHS FOUNDATION TRUST
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
WESTON AREA HEALTH NHS TRUST
WIRRAL COMMUNITY NHS TRUST
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WORCESTERSHIRE HEALTH AND CARE NHS TRUST
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

WYE VALLEY NHS TRUST
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
YORKSHIRE AMBULANCE SERVICE NHS TRUST

Annex B: Renal transplantation

Introduction

528. Nationally specified currencies exist for adult renal (kidney) transplants. The currencies are made up of three components of the care pathway using existing HRGs, which are also applicable to child transplants, as follows:

(a) preparation for transplantation outpatient attendances
- LA10* Live donor screening
- LA11* Kidney pre-transplantation work-up - live donor
- LA12* Kidney pre-transplantation work-up of recipient

(b) the transplant episode including post discharge drugs
- LA01* Kidney Transplant from Cadaver non-heart beating donor
- LA02* Kidney Transplant from Cadaver heart beating donor
- LA03* Kidney Transplant from Live donor
- LB46* Live Donation of Kidney

(c) Post-transplantation outpatients
- LA13* Examination for post-transplantation of Kidney
- LA14* Examination for post-transplantation of Kidney of live donor

529. We recognise that clinical coding is not nationally mandated when a procedure takes place in an outpatient setting and, unless locally mandated, pre and post-transplant HRGs may not be automatically generated. It may be necessary to liaise with the renal unit to manually adjust activity where appropriate to reflect the fact that this pre and post-transplant activity is taking place. We would encourage this issue to be raised with renal clinicians and the clinical coding team to ensure the activity is accurately coded in future. The separate reporting of activity (and costs) against these pre and post-transplant HRGs is essential to recognise the fact that non-transplanting units may undertake this activity but not the transplant itself.

530. Where a kidney is rejected by a patient after discharge from hospital (the inpatient transplant episode), and readmission is required, a new spell of care should be recorded.

531. NHS Blood and Transplant (NHSBT) record all kidney transplants in real time. Trusts should use this information, available from an organisation's renal transplant unit, as a validation check against reference cost activity.

532. As far as possible, costs related to pre and post-transplant activity should not be included within the composite cost of the transplant episode (recipient or donor), but identified and reported separately in HRGs LA10* to LA12* and LA13* to LA14* respectively.

533. All trusts submitting these costs should read *Developing robust reference costs for kidney transplants*[102], published by NHS Kidney Care as a March 2010 report and August 2011 update. It includes a bottom up costing template and a number of basic

[102] http://www.kidneycare.nhs.uk/_Resourcestodownload-Reports.aspx#Devolping%20robust%20ref%20costs%20for%20kid%20transplants%20update

rules:

(a) kidney transplants from deceased donors (HRGs LA01* and LA02*) are carried out as non-electives
(b) kidney transplants from live donors (LA03*) are carried out as electives
(c) non-elective short stays are very unlikely.

Preparation for transplantation

534. All pre-transplantation outpatient activity, related to both recipient and any potential living donor, should be recorded against the appropriate LA10* to LA12* HRG each time the patient is seen within an outpatient clinic, including adult initial assessment and maintenance (i.e. whilst being maintained on the transplant waiting list).

535. All relevant costs should be included, as follows (this is not an exhaustive list):

(a) Initial assessment clinic (suitability for transplant), including:
   (i) Cardiology tests (echocardiogram, ECG, angiogram, exercise ECG)
   (ii) Nuclear medicine tests (stress MIBI)
   (iii) Microbiology tests
   (iv) Registration on local kidney transplant waiting list
   (v) Registration on ODT (UK Transplant) kidney transplant waiting list
(b) Follow up outpatient activity whilst maintaining patient on the list (whilst awaiting transplant), including
   (i) Cardiology tests (echocardiogram, ECG, angiogram, exercise ECG)
   (ii) Vascular lab tests (duplex scans)
   (iii) Nuclear medicine tests (stress MIBI)
   (iv) Pathology (FBC, clotting screen)
   (v) Radiology (chest x-ray, CT abdo, abdo ultrasound).

Transplant inpatient episodes

536. The HRGs related to the transplant inpatient episode will be automatically generated through the Grouper and all relevant costs should be included, as follows (this is not an exhaustive list):

(a) pre operative checks and tests
(b) the kidney transplant procedure (in theatre)
(c) any required readmission to theatre (whilst the patient is still in hospital)
(d) all post operative inpatient care
(e) stent removal
(f) up to 90 days post transplant drugs.

537. The cost of kidney transplants (recipient) should also include the costs incurred of matching to suitable donors. Costs relating to a deceased donor should be included in the composite costs of the relevant recipient HRGs (LA01* and LA02*). Costs related to live donors should be included as part of the relevant donor HRG.

538. Costs related to the retrieval of organs from deceased donor organs are the responsibility of NHSBT and should not be included within the transplant HRG cost.

539. Currencies for antibody incompatible recipient transplantation are still in development. Activity and costs related to these complex transplants should not be included within the transplant HRGs LA01* to LA03* HRGs, but reported separately.

Post-transplantation outpatients

540. All post-transplantation outpatient activity, related to both recipient and any potential living donor, should be recorded against the appropriate HRGs LA13* to LA14*, each time the patient is seen within an outpatient clinic, including annual reviews. Relevant costs include all relevant pathology tests and antibody monitoring.