Reference Costs 2010/11
Collection Guidance
December 2010

Gateway Reference

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For Recipient's Use			

Updated Reference Costs 2010-11 Collection

Costing & Activity Guidance and Requirements - Final

Contents

The Refcosts team would like to thank all contributors for their time and efforts going into this document.

EXECUTIVE SUMMARY

Costing & Activity Guidance and Requirements

This document outlines the mandatory requirements for the 2010-11 reference costs collection. It supersedes costing guidance issued in previous years. It should be read in conjunction with the latest version of the NHS Costing Manual and the Acute Clinical Costing Standards (available at www.dh.gov.uk/nhscosting). ***In a change for 2010-11 this guidance document now contains much of the activity specific costing guidance previously contained within the Costing Manual, the Costing Manual sets out the overall principles of costing which should be adhered to by NHS Organisations.*** **For purposes of clarity should the interpretation of the costing manual be inconsistent with this document, this guidance takes precedence for reference costs purposes.**

There have been changes made to the collection guidance since the 2009-10 collection in 2010. These are outlined in appendix 6. These key changes have been driven by guidance queries following the 2009-10 data collection, and to align with the future direction of Payment by Results policy. Where possible, the guidance continues to maintain consistency with data definitions, with links made to the Data dictionary (NHS Connecting for Health). Therefore, as with last year's collection exercise, the focus for 2010-11 remains one of refinement and increased consistency rather than any significant extension of scope. This is a conscious decision to enable costing teams to focus on improved quality.

The return is mandatory for all NHS providers of services to the NHS. It is also mandatory for commissioning of services for NHS patients whose care is provided by Non-NHS providers. Information is also required for services provided to NHS patients under a sub-contract from a NHS provider. Hospices and Nursing homes are excluded from this requirement.

Review of Reference Costs

The Department published in 2010 the outcomes of the Review of Reference Costs, undertaken in partnership with the Audit Comission. Where possible, any outcomes from the review relating to guidance have been incorporated into this document.

Further information relating to the Review of Reference Costs can be found at the following link:

http://www.dh.gov.uk/en/Managingyourorganisation/NHScostingmanual/DH_104762

Payment by Results (*PbR*)

Reference Costs will continue to support Payment by Results (PbR) policy, and it is expected that the 2010-11 collection will be used to inform the 2013-14 national tariff under PbR. Hence, some refinement to this year's collection has resulted from the requirements of the future development of national tariff. It is therefore essential that the Reference Costs collection be of the highest quality and accuracy.

Patient Level and Information Costing Systems (PLICS)

An increasing number of NHS organisations have moved or are considering moving to patient level costing and produce HRG level costs using a more detailed approach linking resources consumed during each patient event rather than split out high level costs down to HRG level.

It is expected that PLICS systems are fully compatible with HRG4 (for reference costs) resource grouping. If PLICS software providers have not already done so, they should update the software to accept HRG4.

Please note that for the 2010-11 Reference Costs, for all organisations, the collection continues to be on an average cost basis, irrespective of the underlying data supporting these calculations.

SECTION 1

INTRODUCTION

1 **This guidance sets out the mandatory requirements for the reference cost collection, which collects cost and activity data from all NHS provider organisations. This return has been approved by the Review of Central Returns Committee, which mandates its collection across the NHS. Reference costs are part of the financial regime for NHS Trusts, NHS Foundation Trusts, Primary Care Trusts and Care Trusts as designated in relevant NHS legislation and guidance.**

2 In addition, PCTs are required to submit a return for each of their respective Personal Medical Services plus Pilots (PMS+), for the plus element of their agreements. It is the responsibility of PCTs to ensure that appropriate PMS+ data is identified and submitted for each PMS+ organisation, irrespective of whether the PMS+ services have been incorporated into PCT responsibilities or not.

3 **All NHS organisations are expected to comply fully with this guidance, and its timescales. Each organisation must ensure that it has the necessary resources and systems to meet full compliance.**

4 **As part of the Controls Assurance Framework to achieve costing and cost information on a consistent basis, the Accountable Officer will continue to be required to sign the Internal Control Statement. Directors of Finance are required to sign off the data, acknowledging that the information provided has been reconciled internally and is a true and fair view of the services provided, in cost and activity terms.**

5 **This guidance applies to all NHS organisations in existence from 1st April 2010 to 31st March 2011. Where any organisations have ceased to exist in-year, it is the responsibility of successor organisations to ensure reference cost returns are submitted by the mandatory deadline.** This follows the same principle as final accounts returns. For example if in October 2010, Trusts A & B merge into Trust C, Trust C would produce **one** reference costs return for their organisation, incorporating the costs/activities of Trust A and B.

6 If a service transfers from one provider to another (e.g. a Mental Health service integrates from a PCT to an NHS FT) mid year and both organisations continue to operate, then the 'successor principle' above does not apply in this case. If the transferring organisation is ongoing, they should report Reference Cost data for the period of delivering the service.

7 **Users new to Reference Costs may wish to read Appendix 1 of this document before going any further.**

8 **There has been significant change to this document since the publication of the 2009-10 guidance document. Much of the information previously published in the NHS Costing Manual has been subsumed into this document. A much reduced version of the NHS Costing Manual will still be published by the Department but this contains the general costing principles for the NHS. Information regarding costing for reference costs purposes has been incorporated into this guidance.**

9 The service coverage has not been expanded for the 2010-11 collection. However, a number of refinements have been introduced in order to provide further clarity to the guidance, ensure greater comparability, and produce greater robustness in activity and cost data to support tariff development. For example the introduction of a spell based cost collection

10 Please note, as per previous years, the age split for all services will be 18/19 (exceptions to this rule are specifically noted in this guidance). Where an adult is 19 and over, and a child is up to and including 18. This change is to ensure consistency with HRG4 and wider Payment by Results policy.

11 This guidance applies to the provision of health services to NHS patients from NHS resources. In previous years, the Department of Health has set a minimum level of expenditure that must be incurred for costs and activity to be included in the collection exercise. In 2010-11 this de-minimis level remains at 2%, i.e. where the quantum of costs for reference cost purposes is 2% or less of the total level of

expenditure on all NHS services, NHS providers are exempt. However, it is expected that the exemption will apply to NHS Learning Disability service providers only.

12 **The proposed dates for the 2010-11 collection are shown below, please note that there is significant change to the collection timetable for 2010-11. The changes reflect the commitments in the Action Plan in Response to the Review of Reference Costs, which can be found on the NHS Costing pages of the department's website. A more detailed timetable will be published via SHA leads, including information on the Local Validation Period and removal of the formal resubmission window.. The deadline for the submission of completed returns in the 2010-11 collection, to the Department of Health therefore is as below:**

Reference Cost Submission Timetable 2010-11

	Begins	Ends
Local Validation Period[(i)]	04/07/2011	08/07/2011[+]
Collection Period [(ii)]	11/07/2011	22/07/2011[(iii)]

(i) Local Validation Period for organisations for organsiations to validate their data prior to upload into the system, tools and supporting information will be circulated early 2011
(ii) Collection Period includes open submission week and a managed upload day per organisation as per the 2009-10 collection.
(iii) Following the close of the collection period there may be a requirement for organisations to provide data where significant data issues are identified. This will only occur in exceptional circumstances and will be on a DH request only basis
+ In support of the commitment to help organisations get their data right first time, the Costs Collection Team will be available to support organisations to validate their data prior to upload.

13 Please note, that where a PCT has a clear reporting separation in commissioning and provider arms, both divisions are responsible for providing their **own** Reference Cost data. There should be **only one data submission for the organisation** (arrangements should be made locally to determine who submits the single workbook) but the individual arms are responsible for ensuring the data is of a suitable high quality to pass all data validations when submitting the data to the Department of Health.

Quick Reference to this Guidance

14 A wide range of organisation types, providing a number of different services are responsible for calculating and submitting Reference Cost data to the Department of Health. Table 1 below may be useful to give an indication of the chapters of this guidance (and thus which areas of the collection template to complete and submit) should be relevant to your organisation [this is **not** a definitive list of providers who provide healthcare and should only be used as a guide]:

Table 1 – Easy Guide to Reference Cost Guidance Sections

Section	Area	Currency for reporting	Providers affected
2	Elective	FCEs, TFCs and HRG4)	Acute, Community, IS Providers (returned by PCTs).
	Non Elective	FCEs (short and long), TFCs and HRG4 (and in 2010-11 Spells)	Acute, Community, IS Providers (returned by PCTs).
	Day Cases	FCEs, TFCs and HRG4 (and in 2010-11 Spells)	Acute, Community, IS Providers (returned by PCTs).
	Ward Attenders	Reported as part of Outpatient	Acute, Community
	Regular Day/Night Admissions	Admissions and HRG4	Acute, Community
	Day Care Facilities	Patient Days	Acute, Community
3	Outpatient Attendances	Attendances, TFCs, HRG4 and Consultant/Non Led	Acute, Community, IS Providers (returned by PCTs).
	Outpatient Procedures	Procedures and HRG4	Acute, Community, IS Providers (returned by PCTs).

4	A&E – 24hr	Attendances and HRG4 (+DOA)	Acute
	A&E – MIU	Attendances and HRG4 (+DOA)	Acute, Community
	A&E – Non 24hr	Attendances and HRG4 (+DOA)	Acute
	A&E – WIC	Attendances and HRG4 (+DOA)	Acute, Community
5	Adult Critical Care	Bed days, Critical Care Periods and HRG4 (No. organs supported), further disaggregated by CC unit	Acute
	Outreach Services	No activity – just total cost	Acute
	Paediatric Critical Care	Bed days and HRG4	Acute
	Neonatal Critical Care	Bed days and HRG4	Acute
	Coronary Care Units	Bed Days	Acute
	Critical Care Transportation	No. of admissions	Acute
	Cystic Fibrosis Ordinary Admission (Elective or Non-Elective) Bands 1-4	FCEs	Acute
	Cystic Fibrosis Ordinary Admission (Elective or Non-Elective) Band 5	Bed days	Acute
	Hospital at Home / Early Discharge	Team Contacts	Acute, Community, IS Providers (returned by PCTs).
	Home Delivery of Drugs	Delivery of Drugs	Acute, Community, IS Providers (returned by PCTs).
6	Specialist Nursing	Community Contacts, Band, Adult/Child, Face-to-Face/Non	Community
	Nursing Services for Children	Community Contacts, Band, Adult/Child, Face-to-Face/Non **or** No. of Contacts in Financial Year, Adult/Child, Face-to-Face/Non	Community
	School Based Children's Health	No. of Contacts in Financial Year, Adult/Child, Face-to-Face/Non	Community
	District Nursing	Total Contacts, Group and one-to-one services	Community
	Health Visiting Services	Community Contacts, Face-to-Face/Non, Group and one-to-one services No. of vaccinations given	Community
	Community Rehab Teams	By service, Face-to-Face/Non	Community
	Community Paediatricians	No. Team Contacts in Financial Year	Community
	Community Services	Attendance Attendance	Community
7	Podiatry	No.Attendances	Community
	Dietetics	No.Attendances	Community
	Therapy Services	No.Total Contacts in Financial Year	Community
8	Chemotherapy		

	- Same Day/Attendance - Procurement - Delivery	Cycles of Treatment & HRG4 Deliveries & HRG4	Acute, Community, IS Providers (returned by PCTs).
	High Cost Drugs - Admitted Patient Care - Outpatient / Other	 Spells & HRG4 Attendances & HRG4	Acute, Community, IS Providers (returned by PCTs).
	Diagnostic Imaging (excluding APC)	Examinations & HRG4	Acute, Community, IS Providers (returned by PCTs).
	Radiotherapy - Ordinary Admission (Elective or Non-Elective) - Daycase - Outpatients - Other	Admissions Treatments Attendances	Acute, Community
	Rehabilitation - Attendances - Bed Days	 Attendances & HRG4 Bed Days & HRG4	Acute, Community, IS Providers (returned by PCTs).
	Specialist Palliative Care - Ordinary Admission (Elective or Non-Elective) / Day Case - Outpatients / Other	 Bed Days & HRG4 Attendances & HRG4	Acute, Community, IS Providers (returned by PCTs).
	Renal Dialysis	Sessions & HRG4 (Patient Days as a proxy)	Acute, Community
	Patient Transport Services	Attendances	Acute, Community - specifically NOT by Ambulance Trusts (see paragraphs 490 & 491 and 556)
	Hospital Travel Cost Scheme	Attendances	Acute
9	Diagnostic Services	Tests	Acute, Community
	Pathology Services	Tests (& Requests as a memorandum item)	Acute, Community
10	Fitting of Hearing Aids	Attendances	Acute, Community
	Hearing Aids	Aids Issued	Acute, Community
	Repair Services	Repairs	Acute, Community
	Neonatal Screening (audiology)	No. Screens	Acute, Community
11	Obstetrics - Non-Elective - Maternity Outpatients	 LOS (S or L), TFC501 & HRG4 Consultant Led, TFC501 & HRG4	Acute
	Midwife Episodes - Non-Elective - Day Case - Maternity Outpatients	 LOS (S or L), TFC560 & HRG4 TFC560 & HRG4 Non-CL, TFC560 & HRG4	Acute
	Community Midwife Services	HRG4	Acute
	Community Midwife Visits	Visits	Acute
12	Paramedic	Incidents, Responses, Patient Journeys, Calls	Ambulance Trusts
13	Mental Health (MH) - Ordinary Admission (Elective or Non-Elective)	 Occupied Bed Days Occupied Bed Days Occupied Bed Days	Mental Health Providers

	- Ordinary Admission (Elective or Non-Elective) Specialist Services - Secure Units		
	MH Day Care Facilities Regular Attenders	Patient Days, Adult/Child	Mental Health Providers
	MH Consultant Specialist Services - Outpatients - Community	Attendances, DNAs, Face-to-face/Non, First/Follow-Up Attendance Contacts, Face-to-face / Non, First/Follow-Up Attendance	Mental Health Providers
	MH Consultant Non-Specialist Services - Outpatients - Community	Attendances, DNAs, Face-to-face/Non, First/Follow-Up Attendance Contacts, Face-to-face / Non, First/Follow-Up Attendance	Mental Health Providers
	Community MH Teams	Contacts, Face-to-face/Non	Mental Health Providers
	MH Specialist Teams	Contacts, Face-to-face/Non, Adult/Child	Mental Health Providers

Data Quality

15 There continue to be improvements in the quality of data. However, there are still a number of areas where data quality issues are unresolved, e.g. levels of unclassified data, erroneous clinical coding, etc. In response to the outcomes of the review of reference costs, the Department has set out an action plan which outlines a number of proposals aimed at improving the quality of reference costs data Although the Department is working with a number of partners to introduce these improvements, including the Audit Commission who are undertaking audits of the reference costs submission at each NHS organisation. Although the Department is introducingthese measures to improve the quality of data, the onus on the production of sound, accurate and timely data continues to rest with each NHS organisation. Please see **Annex H** for information on how organisations may be required to pre-process some of their activity data to help with the 2010-11 collection.

16 The review of reference costs highlighted the wide and varied uses for reference costs and emphasised the requirement to ensure that cost and activity is reconciled to ensure accuracy prior to sign-off. The implications of poor quality activity and cost data remain far-reaching and will influence the financial position of each NHS organisation under the PbR programme. **The need for high quality data cannot be overestimated.**

Known Areas of Difficulty – 'Reserve Codes'

17 The 2007/08 Reference Cost collection included the introduction of 'Reserve Codes' as an interim solution to allow NHS Reference Cost leads to report a quantum of costs where they were unable to provide robust unit cost data for the unbundled (and A&E) HRG4 categories.

18 'Reserve Codes' are not included in the 2010-11 collection exercise.

Key Principles

19 The above factors reinforce the need to comply with the key underlying principles of the production and development of reference costs. These are: -

- Reference costs are retrospective, and the quantum of costs used in their production should be reconciled to the 2010-11 final accounts. The reconciliation statements that form part of the return are an integral element of the audit trail for this reconciliation. For the 2010-11 reference costs submission, a detailed reconciliation with the accounts return is required as part of the reconciliation statement.

- The mandatory submission is composed of activity and unit cost data, plus the reconciliation statements.

- Reference costs are based on full absorption costing.

- In preparing reference costs, the emphasis is on the cost of delivering a service, and not the funding streams that are used to recover these costs. The services covered are those provided for NHS patients under a range of contractual arrangements.

- Organisations should continue to submit activity and cost data on an FCE basis. Please refer to paragraphs 46/146 for details on Spells based costing.

20 The total expenditure used in the production of reference costs must be reconciled to the final accounts. This will allow full operating expenses, plus the following items as appropriate:-

- The revenue consequences of capital;
- The allowable costs of reorganisation;
- Profit / loss on disposal of fixed assets;
- Interest receivable / payable;
- PDC dividends; &
- Other finance costs as stipulated on the expenditure reconciliation statement.

A detailed reconciliation to the final accounts figures using TRU / PCT (accounting forms) figures is provided in Appendices 2 and 3 of this document.

21 It is also expected that an annual review of overhead apportionments is undertaken. It is important to review apportionments across the individual points of delivery within a service / specialty, and not just the apportionments to individual services / specialties.

22 All NHS organisations, that provide any of the services listed in the subsequent sections, are required to make a submission of all relevant information to the Department of Health as per paragraph 8.

23 In addition, PCTs and NHS Trusts who directly commission or sub-contract services from non-NHS health care providers, **including Independent Sector Treatment Centres**, are required to make a separate composite return. As in previous years' collections**,** NHS organisations are required to make a single set of composite returns for any and all services that are sub-contracted (in the case of Trusts and PCTs acting in their provider capacity) or commissioned (for PCTs acting in their commissioning role) from non-NHS providers. This will ensure that the total cost of treating NHS patients is identified whether the provision is made by NHS or non-NHS providers.

24 **Strategic Health Authorities** have a key role in performance managing the process and in supporting NHS organisations in complying with current guidance and requirements. A lead member of staff is identified for each Strategic Health Authority and contact details can be found at www.dh.gov.uk/pbr (following the link to NHS Costing) Foundation Trusts should contact the Department of Health with any queries direct, at email address pbrdatacollection@dh.gsi.gov.uk

The NHS Information Centre and HRG4

25 HRG4 Categories have been developed by the Information Centre and Department of Health to support the introduction of new clinical areas and Payment by Results (PbR).

26 The full list of HRG4 categories is fine-tuned every year in line with requirements and the 2010-11 Reference Cost collection always uses the HRGs included within the latest Reference Cost Grouper, , and organisations must download the **latest 2010-11 HRG4 Reference Cost Grouper** by clicking the link below:.

http://www.ic.nhs.uk/casemix

A useful mapping of the HRG4 categories across 2006/07 to 2009/10 financial years can be found on the Reference Cost Discussion Forum.

27 **The 2010-11 HRG4 Reference Cost Grouper is supported by the current underlying OPCS-4 classification (see below) and requires submissions relating to Commissioning Data Sets [CDS] covering Admitted Patient Care [including day cases and regular day / night admissions], Adult, Paediatric and Neonatal Critical Care, Outpatients and Accident and Emergency. The new Renal Dialysis core HRGs [subchapter LD] are generated by use of fields from the National Renal [clinical] Dataset rather than from a CDS (please see section 8 for more information).**

28 For the datasets above, Reference Cost data continues to be collected using the format of the HRG4 output, in line with the design of the HRG. The design and subsequent method of cost collection will continue to be reviewed over time in line with policy development.

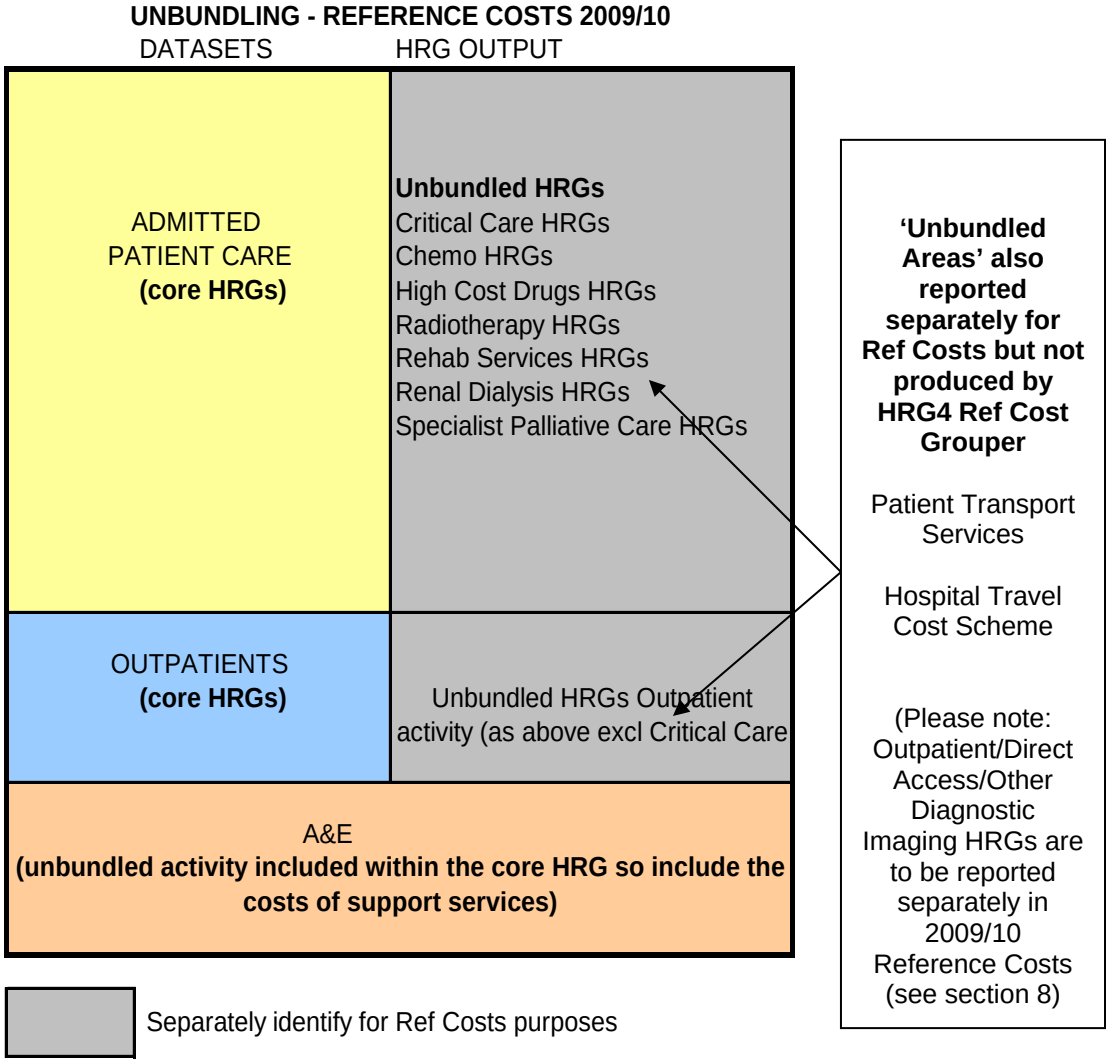
The original HRG4 design concepts are available on the Information Centre website (link below):
http://www.ic.nhs.uk/webfiles/Services/casemix/Prep%20HRG4/HRG4%20design%20concepts%20a.pdf

29 If organisations admit a patient and the patient has a length of stay of zero (for some HRGs, the logic dictates a LOS of zero) then the HRG4 Reference Cost Grouper will **automatically add one bed day after grouping** in the Grouper Reports for these types of patient classifications. This is done to reflect the fact that costs are often apportioned on a bed-day basis and this avoids a zero length of stay incorrectly incurring nil costs.

Any queries regarding HRG4 and/or the output of the HRG4 Reference Cost Grouper should be sent directly to the Information Centre by contacting the IC's Contact Centre on 0845 300 6016 or e-mail enquiries@ic.nhs.uk.

Unbundling

30 The diagram below gives a holistic view of how the unbundling process works for the datasets supporting the 2010-11 HRG4 Reference Cost Grouper



For detail on what to include / exclude for reporting purposes, please refer to the relevant section of this guidance document.

OPCS Procedural Classification

31 As Reference Costs data will be used to inform national tariff, it is essential that the correct procedural classification and minimum data sets are implemented by NHS organisations.

http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/opcs4/opcs-4.5/summarychangeso.pdf

32 To ensure that tariff is correct and accurate reference costs can be delivered, organisations will need to have implemented the OPCS 4.5 classification of Interventions and procedures for the 2010-11 collection.

33 This guidance (where possible) continues to give a more specific example of how to complete the return for those few organisations yet to implement a minimum of OPCS 4.3 codes (latest coding is OPCS4.5). For organisations still in the transitional stage, further advice is provided in section 8 of this guidance.

34 Organisations should note that the coding of activity using the updated OPCS 4.5 classification has been **mandated for use on 1st April 2010** and as such organisations should begin coding at this level to support the **2010-11** Reference Cost collection.

http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/opcs4/opcs-4.5

Trimpoints

35 Admitted Patient Care services primarily use Healthcare Resource Groups (HRGs) as their casemix measure. For the 2010-11 collection, HRG4 Categories are used for reporting this type of data on a Finished Consultant Episode (FCE) and Spells basis.

36 In calculating the HRG length of stay and associated excess bed days, the latest HRG4 (FCE) national trimpoints should be used. These can be accessed from the Information Centre website (http://www.ic.nhs.uk/casemix) and have been calculated using historic data. Further details on how national trimpoints are calculated are available in the methodology paper also accessed at the link above. Updated Trimpoints for 2010-11 will be available in April 2011 (with the Final 2010-11 HRG Reference Cost Grouper – please note that the Test "Beta" version of the Grouper is not expected to include Trimpoints.).

37 To clarify, some HRGs may have a trimpoint of 32,000. The reason such trimpoints have been generated in the past is due to insufficient data available to calculate valid trimpoints or where maximum length of stay logic is included in the HRG4 design. These trimpoints are also valid. More details can be found in the 'Notes' sheet of the Excel Trimpoint workbook, available on the Information Centre website:

http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/healthcare-resource-groups-4-hrg4

38 Excess bed days are those bed days that fall beyond the upper trimpoint for an HRG after truncation. Costs and activity should be reported separately within reference costs. It is expected that the care of patients is less intensive/dependent than at the beginning of the FCE and thus costs will be less per day than for the truncated HRG. Further detail on the costing of excess bed days can be found in the 2010-11 NHS Costing Manual.

39 **All unclassified data (U code HRGs)** have a trim point of zero. All bed days relating to unclassified data for Admitted Patient Care activity **(for Elective and Non Elective, see below for treatment of daycase)** should therefore **be reported as excess bed days** and costed accordingly in line with guidance in the paragraph below. Thus, U code costs may include elements of costs for theatres and pathology, etc. It should be noted that, as in previous years, the costs and activity relating to U codes are **NOT included in Index calculations**.

40 Activity for U code data continues to be required as a memorandum item for **elective and non-elective** data to complete the collection files. As stated above, only excess bed day costs should be reported. No '£ unit cost per FCE' should be reported for elective and non-Elective unclassified HRGs.

Please Note: **U code data reported at day case level should continue to be reported on an FCE and unit cost per FCE basis, given that, by its very nature, there are no bed days associated with day case activity.**

41 For services reported using bed days rather than FCEs, e.g. critical care services, the relevant bed days should be **excluded** prior to the application of the HRG4 national trimpoints.

NHS Connecting for Health

42 Where possible, the requirements of the Reference Cost collection have been aligned with the definitions set out in the NHS Connecting for Health (CFH) data dictionary and commissioning data sets. This guidance links to a number of sections within the CFH website (blue links), where further details can be attained.

Costing of Reference Costs

43 **Many of the principles and mandatory framework for the production of reference costs, previously set out in the NHS Costing Manual, have been incorporated into this document and should continue to form the basis of costing for the reference costs collection.**

44 To ensure that all NHS providers are compared on a consistent basis, details of the definitions to be used and refinements to the standard costing approach that must be adopted for reference costs purposes are detailed below. **Comprehensive information on the overall concepts and approach to costing NHS Services can be found in the revised NHS Costing Manual, which will be available on the internet at www.dh.gov.uk/pbr (following link to NHS Costing pages) as in previous years.**

45 NHS providers are expected to adopt the NHS Costing Manual classifications of direct, indirect and overhead costs as a minimum when attributing, allocating and apportioning their costs to those services that they provide (where accounting records support this). It is desirable that organisations move from classifying costs as overheads, thereby apportioning them, to re-classifying them as indirect costs, which can be allocated to specific service areas. Costs identified as direct in the NHS Costing Manual must be directly attributed to services, and cannot be re-classified as either indirect or overheads. This treatment ensures a minimum degree of comparability.

Spell Based Data

46 **Following 2009/10 reference costs the Department ran a pilot collection of spells data with the support of several software suppliers and 10 volunteer NHS organisations. We are currently working to fully understand the outcomes of this collection (ie. whether the data collected is an appropriate basis for tariff calculation and the current spells guidance is suitably robust).**

The pilot collection proved to be a useful exercise and we are very grateful to those organisations that took part. From our initial understanding it is clear that we are not yet in a position to mandate the collection of spell level data for 2010-11, however we are looking to refine the methodology for the collection of this data. Work has begun around developing a further non-mandatory pilot of spells on a larger scale following 2010-11 reference costs in order to provide sufficient information as to suitability of spell data as a basis for tariff. We will continue to work with the organisations and software suppliers who contributed to the 2009-10 spells pilot in order to refine the spells collection and make this as straight-forward an exercise as possible.

We expect to carry out a further non-mandatory collection of spells data and will be looking to a larger number of organisations to provide spell based reference cost data in 2010-11.

As in 2009-10 reference costs guidance, we encourage organisations to look towards reporting spell data as this may become a part of future reference costs collections in order to support the production of tariff.

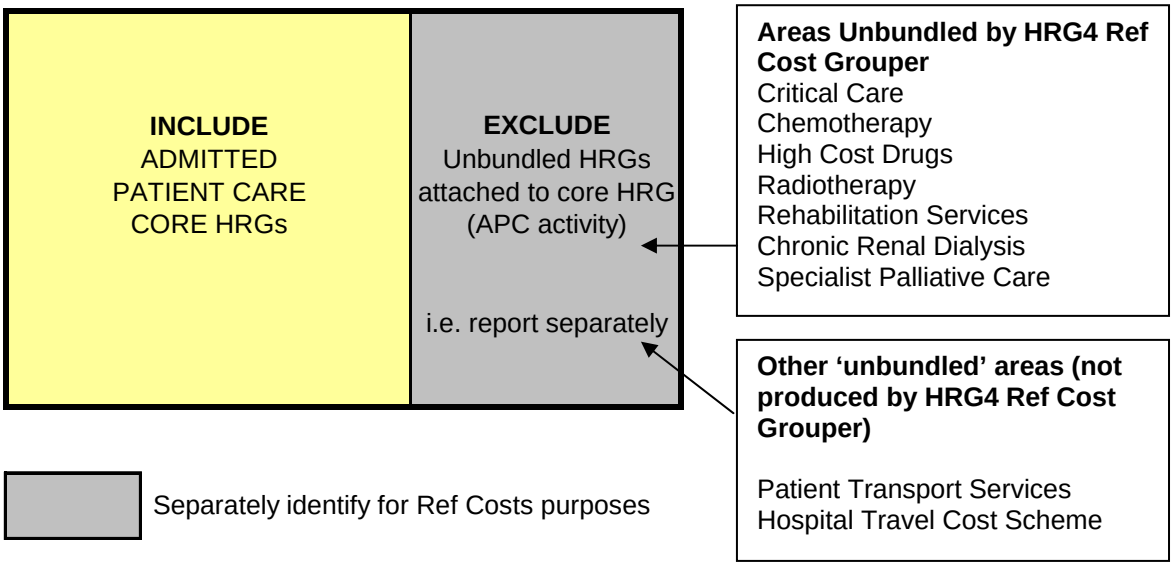
SECTION 2

ORDINARY ADMISSIONS (ELECTIVE OR NON-ELECTIVE), DAY CASES, REGULAR DAY/NIGHT ADMISSIONS AND ATTENDERS AT DAY CARE FACILITIES

This section refers to the following type of patient:

Area	**Currency for reporting**	**Paras**	**Unify2 Reporting Worksheet**
Elective	FCEs, TFCs and HRG4	47-112	Elective and Non-Elective
Non Elective	FCEs (short* and long), TFCs and HRG4	47-112	Elective and Non-Elective
Day Cases	FCEs, TFCs and HRG4	47-111	Daycase
Ward Attenders	Reported as part of Outpatient	113	Outpatient
Regular Day/Night Admissions	Admissions and HRG4	122-125	DCRA
Day Care Facilities	Patient Days	126-130	DCFRAD

47 Admitted Patient Care services (Elective, Non Elective and Day Case) should be reported at an FCE level, using the latest HRG4 Categories. The output of the 2010-11 HRG4 Reference Cost Grouper will attach a core HRG to every FCE. . Please note, only cost and activity data for the **core HRGs** are to be reported for the areas above. Unbundled activity is to be reported separately (see Section 8 of this guidance) **unless specified mentioned (e.g. APC Diagnostic Imaging, Assisted Reproduction Medicine, Cancer MDTs)**:



48 The HRG4 categories designed to separately identify services from the admitted patient care (Elective, Non Elective and Day Case) FCE activity are listed below:

* The Short and Long-Stay categories are mutually exclusive. For example a two-day episode would NOT be recorded as one short stay episode plus an excess bed day (in excess of the short stay), but instead the whole two-day episode would be recorded as a single long stay episode. Therefore we would not expect any aexcess bed days for short stay non-elective activity.

The exception to this rule being UZ01Z where Excess Bed Days should continue to be used as they have in the past.

Service	Area reported in 2010-11 Ref Costs
Chemotherapy	(see section 8)
Radiotherapy	(see section 8)
Specialist Palliative Care	(see section 8)
High Cost Drugs	(see section 8)
Rehabilitation	(see section 8)
Renal Dialysis	(see section 8)
Critical Care	(see section 5)

49 The unit cost and activity for Admitted Patient Care (APC) (Elective, Non Elective and Day Case) should be reported at Healthcare Resource Group (HRG) level (unless otherwise specified). Where a clinician or nurse undertakes APC case activity whilst acting in a **private** capacity, these are not recorded against the NHS organisations activity and cost base and therefore are **excluded** from the exercise from a provider perspective.

50 Activity should, where requested, be reported at Treatment Function Code (TFC) level. The latest TFC reporting list was issued by NHS Connecting for Health in DSCN 02/2007 (February 2007), effective from 1st October 2007. Details of the revised Treatment Function Codes can be found on the NHS Connecting for Health website and **Annex A of this document**.

51 Although most Ordinary Admission (Elective or Non-Elective) services have been included in reference costs since their inception, some areas require refinement to ensure greater consistency, both in costing and activity.

52 The split between Ordinary Admission (Elective or Non-Elective) and Day Case is maintained. NHS providers are expected to continue to separate and return unit cost and activity data for both types of patient admission where both are provided. Day case activity will continue to be separately reported.

53 Confusion has occurred previously where a patient has a planned or expected admission as an Ordinary Admission (Elective or Non-Elective), but is allowed home on the same day. Within a number of patient administration systems, this will be recorded as an Ordinary Admission (Elective or Non-Elective), with a length of stay of zero. To achieve consistency, the following **standard definition of length of stay should be used for Ordinary Admission (Elective or Non-Elective) episodes with a nil length of stay; date of discharge less date of admission plus one.** The HRG4 2010-11 Reference Costs Grouper will add a LOS of one to any episode with a nil length of stay.

54 This definition is consistent with the recording of this data within other financial returns e.g. Trust Financial Returns, and with reference costs in previous years. Note that this adjustment should be made after filtering out the non-FCE activity, e.g. critical care, and after grouping the data. This should be solved by the automating of adding one day for the purposes of reporting Ordinary Admission (Elective or Non-Elective) data in the HRG4 Reference Cost Grouper Reports.

55 Ordinary Admission (Elective or Non-Elective) and day case activity is now included for all but a few NHS services. As a general rule, unless services are specifically listed as being excluded (see Section 16), they should form part of the reference costs collection.

56 As in previous years' collections, the number and cost of excess bed days will be reported separately for elective and non-elective bed days for FCEs. The 2010-11 HRG4 Reference Costs Grouper, issued by The Information Centre, splits these excess bed days between elective and non-elective categories as a matter of course.

Costing

Set up Resource Profiles (Costed HRGs)

57 *Having identified the HRGs, the key conditions/procedures within each HRG need to be determined. The next step, where costs have not already been calculated at a patient level, is to set up a clinical and resource profile for each of these.*

58 *A clinical profile involves detailed discussion with medical and nursing staff to assess what activities are undertaken and resources consumed each time a procedure or treatment of a condition takes place. In the first year of costing new services, this task may require considerable effort, but in subsequent years it may only need refining/updating. Organisations are encouraged to review clinical audit reviews, teaching tools for junior doctors, etc. which are already in existence, as the basis of a number of profiles may exist in other forms.*

59 *The resource profile for each key condition/procedure should include the activity units for each associated costing pool and the associated cost, as well as the variable items used in treating the condition.*

60 *This stage in the process can be extremely time consuming when services are being costed for the first time. Much of the work on this stage can be commenced in advance of final accounts information being made available from analysis of activity levels in previous years. All clinical and resource profiles should therefore be available prior to the production of the final costs so only minor adjustments will be needed when the final costs are being produced.*

61 *In establishing resource profiles, nurse managers/ward managers can readily provide relevant information. There are two areas where you should provide guidance during interviews to ensure that valid results are obtained. These areas are:*

- *averaging. For each condition, the aim is to derive an average usage for each variable item and there will be variations to this average which arise from, for example, differences between the severity of patients' conditions and differences between consultants' clinical practice. It may be necessary to determine the range of usage before arriving at an average. For example, the minimum data sets will give the lengths of stay for a sample of patients and these can be averaged. This does not imply that there is an "average patient".*

- *significance of costs. The nurse managers/ward managers will be able to estimate the quantities of items consumed. Use the information to identify, for example, whether an item has a significant impact on costs and the quantities are important or whether an item is inexpensive. Some care is needed in dealing with high volume/low cost items and the effort should concentrate their use in relation to different conditions.*

62 *Condition based costs are evaluated from internally available data. For example, the unit cost of drugs will be available from Pharmacy. Other sources of cost data include Stores and Sterile Supplies Departments. Care is required with sterile supplies and other departments, so as not to use an internal charge which may include an allocation of fixed costs; either identify the true variable cost or make an approximation to it.*

63 *Time-based costs are evaluated by using an average unit cost for a bed-day, theatre hour/session, or outpatient attendance, derived from the appropriate costing "pool".*

64 *Two examples of the resource profiles are shown below to illustrate the above process.*

Example 1

TREATMENT FUNCTION: GENERAL MEDICINE
POINT OF DELIVERY: INPATIENT NON ELECTIVE
HRG: AA 22Z: NON-TRANSIENT STROKE OR CEREBROVASCULAR ACCIDENT
ICD CODE: I634: CEREBRAL INFARCTION DUE TO EMBOLISM OF CEREBRAL ARTERIES

COSTING POOL	POOL TYPE	MEASURE	UNITS	COST/ MEASURE £	TOTAL COST £
MEDICAL STAFF	TIME	BED DAYS	9.00	20	**180**
WARD	TIME	BED DAYS	9.00	20	**180**
WARD	EVENT	ADMISSION	1.00	20	**20**
NURSING	TIME	BED DAYS	9.00	70	**630**
DIAGNOSTICS:-					
- PLAIN FILM RADIOLOGY	EVENT	BANDED TESTS	2.00	20	**40**
- PATHOLOGY TESTS	EVENT	BANDED TESTS	10.00	6	**60**
THERAPIES:-					
- OCCUPATIONAL THERAPY	EVENT	SESSION	2.00	25	**50**
- SPEECH THERAPY	EVENT	SESSION	2.00	25	**50**
- PHYSIOTHERAPY	EVENT	SESSION	5.00	27	**135**
TOTAL COST					**1,345**

Example 2

TREATMENT FUNCTION: GENERAL SURGERY
POINT OF DELIVERY: INPATIENT NON ELECTIVE
HRG: F Z20B: APPENDECTOMY PROCEDURES 19 YEARS & OVER WITHOUT MAJOR CC
ICD CODE: H018: EMERGENCY EXCISION OF APPENDIX OS

COSTING POOL	POOL TYPE	MEASURE	UNITS	COST/ MEASURE £	TOTAL COST £
MEDICAL STAFF	TIME	BED DAYS	3.00	100	300
WARD	TIME	BED DAYS	3.00	120	360
WARD	EVENT	ADMISSION	1.00	20	20
THEATRE	TIME	THEATRE TIME	0.75	600	450
THEATRE	EVENT	THEATRE TIME	1.00	60	60
TOTAL COST					**1,190**

Establishing Costed HRGs.

65 *The data produced are now used to determine average HRG costs. By relating the costs to the specific activity for each condition/procedure, a weighted average HRG cost is derived, by multiplying the cost for each procedure/condition by the total number of episodes/spells for each condition/procedure. Any significant changes experienced will need to be recognised, as well as any changes in casemix resulting in a change in the range of relevant HRGs. This gives the total costs for each of the procedures/conditions costed, which are added together and divided by the total number of episodes/spells for the costed codes within the HRG. This calculation produces a weighted average HRG cost. This average cost is applied to all of the episodes/spells for the HRG within the point of delivery.*

66 *A check should be made at this point to ensure that at least 80% of the total costs and activity are being recovered. The additional cost associated with the excess bed days will need to be identified and this is covered below in costing the residue.*

67 *Two examples of the calculation of weighted HRG costs are shown below.*

Example 1

TREATMENT FUNCTION: GENERAL MEDICINE
POINT OF DELIVERY: INPATIENT NON ELECTIVE
HRG: A A22Z: NON-TRANSIENT STROKE OR CEREBROVASCULAR ACCIDENT

NO.	ICD CODE	DESCRIPTION	COST	EPISODES	TOTAL COST
			£		£
1	I634	CEREBRAL INFARCTION DUE TO EMBOLISM OF CEREBRAL ARTERY	1,855	40	**74,200**
2	I650	OCCLUSION AND STENOSIS OF VERTEBRAL ARTERY	1,748	20	**34,960**
3	I661	OCCLUSION AND STENOSIS OF ANTERIOR CEREBRAL ARTERY	2,147	10	**21,470**
4	I672	CEREBRAL ATHEROSCLEROSIS	2,239	10	**22,390**
				80	**153,020**

WEIGHTED AVERAGE COST [153,020/80] FOR

HRG AA22Z : NON-TRANSIENT STROKE OR CEREBROVASCULAR ACCIDENT **£1,913**

Example 2

TREATMENT FUNCTION: GENERAL SURGERY
POINT OF DELIVERY: INPATIENT NON ELECTIVE
HRG: F Z20B: APPENDECTOMY PROCEDURES 19 YEARS & OVER WITHOUT MAJOR CC

NO.	ICD CODE	DESCRIPTION	COST	EPISODES	TOTAL COST
			£		£
1	H018	EMERGENCY EXCISION OF APPENDIX 0S	1,190	60	**71,400**
2	H022	PLANNED DELAYED APPENDICECTOMY NEC	1,361	20	**27,220**
3	H038	OTHER OPERATIONS ON APPENDIX 0S	998	10	**9,980**
				90	**108,600**

WEIGHTED AVERAGE COST [108,600/90] FOR

HRG FZ20B : APPENDICECTOMY PROCEDURES 19 YEARS & OVER WITHOUT MAJOR CC £1,207

Costing the Residue

68 *Within each point of delivery, the residue will consist of two elements:*

- *the above average cost relating to the excess bed days;*
- *the uncosted residue relating to the low cost and low volume HRGs.*

Prepared using the resource profiles, the costed HRGs should ideally cover 100% of each services' costs for treated patients, with a minimum of 80% of each services' covered. This process may lead to a residue of costs for each treatment function covering the less frequent procedures/diagnoses. These costs provide a "standard cost" for the remaining activity at HRG level. All costs should be attributed to a HRG even where a profile has not been produced. For reference costs purposes, standard costs are denoted by a flag ("S") in the reference costs collection.

69 *While standard costs are accepted for this residual activity, it should be noted that increasingly, most acute service providers are costing 100% of activity using profiles. In addition, if standard costs are used, these should be reviewed and weighted as necessary. Examples of standard costs reflect some of the low costs recorded at HRG level in the past. Organisations are expected to apply logic and local knowledge to these figures, e.g. the cost of treating a bunion would generally be expected to be lower than for an appendectomy, when both are in General Surgery, even though the cost for each procedure is submitted as a standard cost.*

70 *For Elective and Non-Elective Inpatients there will be three groups of cost analysis within each high level control total:*

- *HRG Based Costs - for truncated episodes/spells;*
- *Cost of Excess Bed days;*
- *Residual Cost - not profiled, but submitted at HRG level using standard costs.*

71 *For day cases there will be:*

- *HRG Based Costs;*
- *Residual Cost - not profiled, but submitted at HRG level using standard costs.*

72 *The cost per day, for the excess bed days, should include only the costs associated with the time based ward costing pool, and any associated variable costs. This is primarily hotel and nursing costs and drugs, dressings, etc. It is not expected to include expensive costs except in very exceptional circumstances. This cost per day is multiplied by the number of excess bed days to give the total cost associated with the excess bed days.*

73 *Once the total cost associated with the excess bed days has been established, the total cost of the uncosted activity can be identified. As a minimum requirement this should be divided by the number of uncosted episodes/spells to produce a simple average cost per residual episode/spell. This may be refined if data is available locally. These FCEs/Spells need to be attributed to the relevant HRG even where these HRGs have not been resource profiled. This will limit distortions to overall efficiency calculations.*

74 *Once these steps have been completed, the production of resource profiles and the residual unprofiled activity will have been costed. As a final check, a comparison with the previous level control totals should ensure that all relevant costs have been included in the process.*

Selection of HRGs

75 *Previously HRGs were selected at treatment function level, which resulted in some HRGs being costed for some admission types which were relatively small. By selecting the HRGs covering at least 80% at each point of delivery, within each treatment function, this may result in variations in the HRGs which are covered in each point of delivery. Nevertheless, by adopting this approach, the HRGs which are selected and costed will better reflect the minimum level of costs and activity rather than an aggregated approach for the treatment function which can be defined differently dependent on the organisational structure.*

Truncating / Trimming of Activity

76 *4.8.1 The application of trimpoints continues to remain Mandatory. The production of excess bed day information, for 2010-11 at an FCE level, is of importance to NHS providers and their commissioners.*

77 *The cost of an excess bed day can be profiled and subsequently produced by HRG (if this is particularly high) or using a standard cost. However, these costs and activity must be reported by individual HRG, within that treatment function, or at organisation wide level (999) if this is the provider's approach to costing.*

78 *Given that the cost of an excess bed day may vary with the patient type, i.e. for a planned (elective) or emergency (non-elective) admission, the number and costs of excess bed days are reported separately for elective and non-elective excess bed days.*

79 *Unclassified data (U code HRGs)1 by definition, have a trim point of zero. All bed days relating to unclassified data should therefore be reported as excess bed days and costed accordingly. It should be noted that the costs and activity relating to U codes are excluded from the Index calculations. Currently, the national tariff value attributed to U codes is zero. This move should encourage an evaluation of this activity to minimise this recording.*

[1] See NHS IC guidance as to why activity groups to the U code HRG

Costing the Residue

80 *Excess bed days need to be calculated, as a minimum, on the basis of the total cost of these excess bed days divided by the number of excess bed days. These costs should include primarily low intensity nursing, drugs, dressing and hotel costs except in exceptional circumstances.*

81 *Activity which has not been resource profiled, should be attributed, as a minimum an average treatment function cost. These FCEs should then be attributed to an HRG and these costs should be reported under the respective HRG.*

Alternative Service Delivery

82 Following moves towards regulation of a range of therapists, it seems appropriate to clarify the costing guidance in this area. Where therapists and practitioners such as chiropractors, acupuncturists, etc. form part of a team providing a range of services, for example, in orthopaedics, pain management, etc., their costs and associated activity, (as well as related oncosts) should be included in the respective cost pool. This approach is consistent with the principles of full absorption costing and matching costs to the services that generate them.

83 Where services provided by these practitioners are discrete services / clinics, e.g. aromatherapy massage, acupuncture, these services are still excluded.

Additional Points to Note

Assisted Reproduction Medicine

84 Since the introduction of HRG4, Reference costs for assisted reproduction medicine have been collected. In recent years these HRGs have been removed, updated and replaced with those below (MC06Z – MC14Z) to more accurately capture the activity within the pathways. These HRGs are generated from procedure codes currently available under OPCS-4.5.

Table 2 – Updated Assisted Reproduction Medicine HRGs for 2010-11

HRG	Label
MC06Z	Collection of Sperm
MC07Z	Intra-uterine insemination with super ovulation
MC08Z	Intra-uterine insemination with super ovulation with donor
MC09Z	Intra-uterine insemination without super ovulation
MC10Z	Intra-uterine insemination without super ovulation with donor
MC11Z	Implantation of Embryo
MC12Z	Oocyte Recovery
MC13Z	Donor Oocyte Recovery
MC14Z	Oocyte Recovery with Intracytoplasmic Sperm Injection

85 However, these HRGs are not designed to capture the cost of the drug regimens for In vitro Fertilisation (IVF) or the high cost Gonadotropins used in Intra-uterine Insemination (IUI). PbR development are still looking to develop this area, and as a result, we expect to extend the collection to include the additional HRGs in Table 4 in the future (we would expect that **organisations have already started to look into the collection of this data from 1 April 2010).**

Table 3 – Additional HRGs (HCD data) required for IVF in 2010-11

HRG	Label	Activity	Unit Cost
MD01A	IVF Regimen 1 (Ultra Short Protocol) - Low dose	Total No. of prescriptions	cost per prescription (i.e. for each treatment/cycle of each regimen/HCD).
MD01B	IVF Regimen 1 (Ultra Short Protocol) - High Dose	Total No. of prescriptions	cost per prescription (i.e. for each treatment/cycle of each regimen/HCD).
MD02A	IVF Regimen 2 (Short Protocol) - Low Dose	Total No. of prescriptions	cost per prescription
MD02B	IVF Regimen 2 (Short Protocol) - High Dose	Total No. of prescriptions	cost per prescription
MD03A	IVF Regimen 3 (Long Protocol) - Low Dose	Total No. of prescriptions	cost per prescription
MD03B	IVF Regimen 3 (Long Protocol) - High Dose	Total No. of prescriptions	cost per prescription
MD04A	IVF Regimen 4 (Ultra Long Protocol) - Low Dose	Total No. of prescriptions	cost per prescription
MD04B	IVF Regimen 4 (Ultra Long Protocol) - High Dose	Total No. of prescriptions	cost per prescription
MD05A	IVF Regimen 5 (Antagonist Protocol) - Low Dose	Total No. of prescriptions	cost per prescription
MD05B	IVF Regimen 5 (Antagonist Protocol) - High Dose	Total No. of prescriptions	cost per prescription
HCD	Gonadotropins	Total No. of prescriptions	cost per prescription

86 To manage this, for the 2010-11 collection, we continue to collect the core HRG data for activities (MC06Z – MC14Z) and to report the ten regimens (i.e. MD01Z- MD05Z) and the high cost drug (Gonadotropins) separately as excluded services. For 2010-11 these regimens have been extended to low dose - 200 units or less, and high dose - greater than 200 units.

87 To clarify, if reporting activity for the Assisted Reproduction Medicine HRGs, please **exclude the cost (including the administering cost) and activity** of the 10 regimens and HCD data (Table 3) from core HRGs MC06Z - MC14Z in your 2010-11 Reference Cost return. **As per previous years, please report the cost and activity as per Table 3 separately in the PSSC worksheet (Analysis of Services Excluded) within the 'Reconciliation Statement' workbook.**

- Exclude from core HRGs
- Do not include in High Cost Drugs HRGs
- Include in Reconciliation Statement (PSSC worksheet)

88 This reporting should lead to more robust data for national tariff calculation. *Note - if you are unable to collect unit cost then please provide total cost and activity value of 1*

89 The 10 IVF Regimens/Protocols should be standard across the Assisted Reproductive Medicine Units and should be readily identifiable by pharmacy departments.

Clinical Negligence Scheme for Trust (CNST)

90 Clinical Negligence Scheme for Trust (CNST) premiums should be treated as an overhead to the relevant specialty, and then weighted across all patient types and activity to reflect the type of claims that arise. When allocating CNST premiums, it should be noted that maternity services often incur a much higher CNST premium than most other services, to reflect the majority of sizable claims that arise

from delivery events. This should be accurately reflected in the relevant cost pool[s] when determining the unit costs of all types of maternity activity. Although the majority of claims arise at the point of actual delivery, causation could be linked to events that happen earlier in the patients' care.

Implantible Defibrillators

91 HRG4 include specifically designed HRGs to identify implantable defibrillators automatically through the grouper and so no additional separate identification is required.

Transplantation

92 Please note that all transplantation outpatients **are separately identified within the outpatient classification** (see paragraphs 182 and 183).

Bone Marrow Transplantation

93 As per previous years, please continue to use the Bone Marrow Transplant HRG4s **(SA19Z – SA23B)** to report cost/activity as Admitted Patient Care (Elective, Non Elective and Day Case) within the existing collection structure. New OPCS-4.5 codes and HRGs (SA26A-SA28B) were introduced for Peripheral Blood Stem Cell Transplantation in 2008/09. These should be reported in the same manner as the Bone Marrow Transplant HRGs are with the existing collection structure

94 Post transplantation drugs, particularly anti-rejection drugs are a significant cost driver and these have a significant distorting effect on outpatient costs after a patient is discharged as an Ordinary Admission (Elective or Non-Elective). In many cases, these costs are treated as an overhead across a wider category of patients. To address the concerns of NHS commissioners and providers about the costs of these services, post transplantation outpatients **are separately identified within the outpatient classification**. This applies across all transplantation services and not just bone marrow transplantation.

95 As for all transplantation services, the general principle for Reference Costs purposes is the costs and activity relating to the **recipient** of a transplant are reported using the appropriate transplant HRG / service code category, whilst the cost and activity relating to a transplant **donor** are reported using the relevant HRG as appropriate **(e.g. SA18Z Bone Marrow Harvest and Peripheral Blood Stem Cell Harvest).** This approach should ensure that all relevant activity is captured and reported.

Kidney Transplants[2]

Kidney Transplants - Recipient

96 Kidney (Renal) Transplants were previously collected as Specialist Services within the new collection structure. The HRG4 categories include a more refined classification for renal transplantation activity. Therefore, this activity should now be recorded and costed, using the HRG4 categories, as Admitted Patient Care (Elective, Non Elective, and Day Case) within the collection structure.

97 Within reference cost returns, organisations should check that activity has been recorded correctly as follows: A cadaver kidney transplant (HRGs LA01A – LA02B) ie from a deceased donor would be carried out as a non elective procedure only. A kidney transplant from a live donor (HRGs LA03A & LA03B) would be carried out as elective procedures only. Kidney transplants should not have a length of stay of less than 2 days unless the patient has died in theatre or within 1 day of the surgery. These 'rules' are detailed in Annex I at the end of this guide.

[2] A bottom up cost template is available to download from the NHS Kidneycare website at http://www.kidneycarematters.nhs.uk/i/assets/Transplant_cost_template_adult_recipient_Nov09.xls. It is recommended that this template is utilized to help validate local 'top down' developed unit costs for kidney transplantation. The cost template, together with the ref cost fact sheet (Annex I) were developed during a project led by NHS Kidneycare (during 2009), to help improve the quality of costs for kidney transplants. A copy of the final report will be available from www.kidneycare.nhs.uk by mid February 2010

98 For patients who are on a renal transplantation programme[3] and are admitted to a renal transplant ward for any reason other than the receipt of transplantation, the costs and activity should be reported using the appropriate (non-transplant) HRG within the Nephrology treatment function code (361). This clarification of reporting treatment should ensure greater comparability and consistency in future collections.

Kidney Transplants - Donor

99 The cost of kidney transplants should include the costs incurred of matching to suitable donors. For live donors there is now a separate HRG for recording the cost and activity of the pre-transplantation work up i.e. LA11Z Kidney pre-transplantation work-up – live donor, and for the donation itself i.e. LB46Z Live Donation of Kidney

100 The cost of kidney transplants from a non-live (cadaver) donor should be included in the composite costs of the relevant recipient HRGs (LA01A – LA02B).

Spinal Cord Injuries

101 Specialist Spinal Cord Injuries Units have been reported separately since 2001/02, in line with specialist commissioning definitions for these services. **Only eight units** have been identified under the specialist commissioning work, **these units (and only these units) should use specialty/treatment function code 323 to submit details about spinal cord injuries patients and associated activity.** The designated units are:

i) The London Spinal Injuries Unit, Royal National Orthopaedic Hospital (Stanmore), The Royal National Orthopaedic Hospital NHS Trust
ii) The Duke of Cornwall Spinal Treatment Centre, Salisbury District Hospital, Salisbury Health Care NHS Trust
iii) National Spinal Injuries Centre, Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust
iv) The Princess Royal Spinal Injuries Unit, Northern General Hospitals Division, Sheffield Teaching Hospitals Foundation NHS Trust
v) Yorkshire Regional Spinal Unit, Pinderfields General Hospital, Mid Yorkshire Hospitals NHS Trust
vi) Regional Spinal Injuries Centre, Southport & Formby District General Hospital, Southport & Ormskirk Hospital NHS Trust
vii) Middlesbrough Golden Jubilee Spinal Injuries Centre, James Cook University Hospital, South Tees Acute Hospitals NHS Trust
viii) The Midland Centre for Spinal Injuries, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust.

102 Some teaching hospitals (outside the above specified list) still have concerns about the spinal work they undertake and the appropriateness of some of the existing HRGs to accurately reflect this activity. For 2010-11, these NHS Trusts should continue to use the HRG4 and outpatient classifications. No organisation should exclude these services from their reference costs submission.

Well / Healthy Babies

103 For the purposes of reference costs, activity under **both** the HRG PB03Z 'Healthy Baby' and Treatment Function Code 424 should be **excluded from the return** as this is the equivalent of 'Well Babies',

[3] Central oversight of renal transplantation in the UK is provided by the Division of Organ Donation and Transplantation (ODT) of NHS Blood and Transplant (NHSBT), and this organisation is responsible for managing the national transplant database and waiting list; overseeing kidney allocation and collecting mandatory data on transplant outcome and transplant centre performance (http://www.organdonation.nhs.uk/ukt/statistics/statistics.jsp) . All kidney transplants are recorded in real time through the Duty Office at ODT. As a matter of course, this information should be used as a validation check against reference cost activity and is available from your renal transplant unit.

already excluded from the collection (see section 16). Costs for this activity should be counted in with the mother.

Devices

104 Please note, the cost and activity for 'Devices' continue to form part of the **Admitted Patient Care** (Elective, Non Elective and Day Case) data. **As per previous years, for tariff development purposes, please provide (where appropriate) the total cost of the devices listed in Annex B within Statement Z in the Reference Cost return.**

Bone Anchored Hearing Aids

105 **New HRGs have been introduced for the recording of procedures relating to bone anchored hearing aids (BAHAs). For reference costs 2010-11 costs and activity for fixture of a BAHA should be reported against CZ27Z (Fixture of Bone Anchored Hearing Aids), fitting of a BAHA should be reported against CZ28Z (Fitting of Bone Anchored Hearing Aids). It is expected that the cost of the device should be included within CZ28Z (ie. the procedure for fitting the device).**

106 Please note, Outpatient Maintenance of BAHAs remains excluded from reference costs (see Section 16). Please see section 10 for more on Audiology Services.

Short Stay Activity [known as 'Admission / Pre-Admission Wards, Assessment Units and Observation Wards' prior to 2007/08]

107 'Short-stay' activity/costs are vital to help inform the development of the short stay emergency adjustment for tariff calculation and for the 2010-11 collection, we continue to collect data to inform this adjustment.

108 For 2010-11, short-stay activity will continue to be collected based on 'length of stay' (LOS).

109 For reporting purposes, you must separately identify the number of FCEs and the average unit cost of **ALL Non-Elective** activity only (HRGs) as follows:

- Short stay – LOS of less than or equal to 1-day (the HRG4 2010-11 Reference Costs Grouper automatically adds 1-day to Non-Elective HRGs with zero LOS so 'short stay' should always be HRGs with LOS of 1
- Long Stay – LOS of more than 1-day

We would not be expect organisations to report any excess bed day information (activity and/or unit cost) for Non-Elective Short Stay activity. Anything with a stay of 1-day or above should, by definition be reported as Non-Elective Long Stay.

110 Please note, at this stage we are collecting short (and long) stay data for **all non-elective activity** (**not** emergency non-elective) to provide flexible data for future tariff calculation, **However, future collections may ask for the LOS split at 'emergency' non-elective level.** If this data is required, then the PbR Team will provide further information on the admission methods, which fall under this reporting category..

111 The HRG4 Reference Cost Grouper reports are created at individual FCE level, including episode duration field, which provides the length of stay (in days). This level of data can then be fed into costing software on this basis.

112 The format of the collection structure (for short stay/ long stay non elective activity) is expected to follow that of previous year's collections as shown below (using dummy data):

Data type	Patient Type Code	Treatment Function Code	HRG Code	Unit Cost per FCE	No. FCEs	No. Inlier Bed Days	Unit Cost per Excess Bed Days	No of Excess Bed Days
OWN	NEI_**S**	501	AA01Z	100	25			
OWN	NEI_**L**	501	AA02Z	112	30			

Ward Attenders

113 It remains important to correctly identify and cost different types of ward attenders, and they continue to be collected and recorded as outpatient activity, in line with DSCN 32/2004.

Activity and cost data relating to those patients attending for examination or treatment by a Doctor / Nurse should be reported as part of the composite outpatient return, at Treatment Function level.

Although no designated reporting worksheet exists for Ward Attenders, the cost and activity should be reported as an Outpatient under the appropriate Treatment Function Code.

Multiple Trauma

114 **The generation of multiple trauma HRGs has been completely redesigned by the NHS Information Centre (NHS IC) following work with the National Clinical Director for Trauma and the Regional Trauma Networks Programme at the Department of Health, under the supervision of the Orthopaedic Expert Working Group (EWG).**

A system of scoring has been introduced with score values being generated based on the diagnoses and procedures within an episode or spell for each patient. The HRG4 Reference Costs Grouper subsequently allocates the patient to a HRG based on the scores generated (please note - the grouper does not output these scores). The grid containing the scores used can be found in the chapter VA supporting documentation, see below.

115 **This new system of HRG generation reflects the complexity of patient requirements for both medical and surgical treatment and enables increased resource consumption to be accurately captured as applicable procedures and diagnoses will contribute to the total score prior to an HRG being assigned.**

HRGs and Labels

VA10A Multiple trauma diagnoses, score <=23 with no interventions
VA10B Multiple trauma diagnoses, score 24 - 32 with no interventions
VA10C Multiple trauma diagnoses, score 33 - 50 with no interventions
VA10D Multiple trauma diagnoses, score >=51 with no interventions
VA11A Multiple trauma diagnoses, score <=23 with interventions, score 1 – 8
VA11B Multiple trauma diagnoses, score 24 - 32 with interventions, score 1 - 8
VA11C Multiple trauma diagnoses, score 33 - 50 with interventions, score 1 - 8
VA11D Multiple trauma diagnoses, score >=51 with interventions, score 1 - 8
VA12A Multiple trauma diagnoses, score <=23 with interventions, score 9 - 18
VA12B Multiple trauma diagnoses, score 24 - 32 with interventions, score 9 - 18
VA12C Multiple trauma diagnoses, score 33 - 50 with interventions, score 9 - 18
VA12D Multiple trauma diagnoses, score >=51 with interventions, score 9 - 18
VA13A Multiple trauma diagnoses, score <=23 with interventions, score 19 - 29

VA13B	Multiple trauma diagnoses, score 24 - 32 with interventions, score 19 - 29
VA13C	Multiple trauma diagnoses, score 33 - 50 with interventions, score 19 - 29
VA13D	Multiple trauma diagnoses, score >=51 with interventions, score 19 - 29
VA14A	Multiple trauma diagnoses, score <=23 with interventions, score 30 - 44
VA14B	Multiple trauma diagnoses, score 24 - 32 with interventions, score 30 - 44
VA14C	Multiple trauma diagnoses, score 33 - 50 with interventions, score 30 - 44
VA14D	Multiple trauma diagnoses, score >=51 with interventions, score 30 - 44
VA15A	Multiple trauma diagnoses, score <=23 with interventions, score >=45
VA15B	Multiple trauma diagnoses, score 24 - 32 with interventions, score >=45
VA15C	Multiple trauma diagnoses, score 33 - 50 with interventions, score >=45
VA15D	Multiple trauma diagnoses, score >=51 with interventions, score >=45

116 **For Reference Costs 2010-11 we would expect Major Trauma Centres' activity to be concentrated in the higher scoring HRGs, however this is not restrictive and costs for complex patients may be returned from a variety of providers until trauma networks are established.**

117 **For further information on the new Multiple Trauma HRGs please see the 'Introduction to Chapter VA' document published by the NHS Information Centre. This will be published as part of the documentation suite alongside the HRG4 2010-11 Reference Costs Grouper in 2011.**

http://www.ic.nhs.uk/services/the-casemix-service/using-this service/reference/downloads/costing

Gastrointestinal Tract Endoscopies

Introduction

118 **The gastrointestinal tract (GI) endoscopy HRGs were completely redesigned by the NHS Information Centre (NHS IC) working with the Digestive System Expert Working Group (EWG) for 2009/10. The activity maps to HRGs dependant on site and type of endoscopy as well as whether purely diagnostic, diagnostic with biopsy or therapeutic. There are also HRGs for combined upper and lower GI tract endoscopies.**

HRGs and Labels

FZ51Z	Diagnostic Colonoscopy 19 years and over
FZ52Z	Diagnostic Colonoscopy with biopsy 19 years and over
FZ53Z	Therapeutic Colonoscopy 19 years and over
FZ54Z	Diagnostic Flexible Sigmoidoscopy 19 years and over
FZ55Z	Diagnostic Flexible Sigmoidoscopy with biopsy 19 years and over
FZ56Z	Therapeutic Flexible Sigmoidoscopy 19 years and over
FZ57Z	Diagnostic or Therapeutic Rigid Sigmoidoscopy 19 years and over
FZ58Z	Endoscopic or Intermediate Large Intestine Procedures 18 years and under
FZ60Z	Diagnostic Endoscopic Procedures on the Upper GI Tract 19 years and over
FZ61Z	Diagnostic Endoscopic Procedures on the Upper GI Tract with biopsy 19 years and over
FZ62Z	Diagnostic and Intermediate Procedures on the Upper GI Tract 18 years and under
FZ63Z	Combined Upper and Lower GI Tract Diagnostic Endoscopic Procedures
FZ64Z	Combined Upper and Lower GI Tract Diagnostic Endoscopic Procedures with biopsy
FZ65Z	Combined Upper and Lower GI Tract Therapeutic Endoscopic Procedures

Costing

119 **When costing the activity it would be expected that the overwhelming majority of pathology costs would be included within the "with biopsy" HRGs (although therapeutic cases may also involve biopsies).**

120 **The costs assigned to the therapeutic HRGs should take account of the longer operation time and the cost of the disposables e.g. snares, clips, stents and the extra nursing resource (time and numbers) and the likely higher level of endoscopist required (consultant rather than specialist nurse etc).**

121 **The costs assigned to the HRGs for combined upper and lower GI tract endoscopies needs to take into account the longer operation time, the double instrument use, and the extra nursing resource involved in undertaking multiple procedures at the same time.**

Regular Day /Night Admissions

Regular Day Admissions *(also known erroneously as Regular Day Attendances)*

122 In activity terms, this is recorded as a series of admissions, with the Patient Classification recorded as 'National Code 03 Regular Day Admission'.

123 These are patients admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who are discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an Ordinary Admission (Elective or Non-Elective). The series of regular admissions ends when the patient “no longer requires frequent admissions". These admissions will be shown separately, but will need to be matched to the relevant HRG4 classification.

124 Attendances for specialist care such as Radiotherapy, Renal Dialysis, Cystic Fibrosis, etc, should be reported through the unbundled / specialist services element of the return, even where these services are delivered by regular day admissions. For specialised services, all costs and activity are reported together, regardless of the setting in which the care is delivered.

Regular Night Admission *(also know erroneously as Regular Night Attendances)*

125 For reference costs, in activity and cost terms, these should be treated in the same way as regular day admissions (paragraphs 122-124 above). In reporting this data, this activity and unit cost information will not be shown separately from regular day admissions. The return will identify regular day / night admissions in total.

All other aspects of the guidance for Regular Day Admissions equally apply to Regular Night Admissions.

Regular Attendances at Day Care Facilities

126 A range of services are provided through NHS Day Care Facilities. In costing these services, the definition of day care facilities, taken from the NHS Data Dictionary, should be used.

127 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 and over 5 days this gives 100 patient days. The basis for inclusion will remain as the total number of patient days and a unit cost per day, for each category. Where patients attend for only part of a day, a conversion should be made from a part day attendance to a patient day e.g. a morning only attendance = 0.5 patient days.

128 The 2010-11 collection requires that the costs and activity for these day hospitals/centres/units form part of the collection for elderly, stroke, and mental health services. Centres catering primarily for the long term physically disabled and learning disability patients continue to be excluded (as all other services for these patient categories are also excluded).

129 The lack of routinely collected patient / client group information is of concern in assessing the services provided through these units / hospitals. Available data is limited to patient days, and until further developments are achieved in activity recording terms, patient days will continue to be the activity and unit cost measure used for reference costs submissions.

130 Note that any additional costs that are incurred when an Ordinary Admission (Elective or Non-Elective) concurrently attends a day care facility (and where their bed is not filled, but is retained for their later use) should be removed from the total cost of the day care facility and be reported as part of the composite cost of that Ordinary Admission (Elective or Non-Elective) care. No day care facility activity should be counted for such patients.

Community Hospitals

131 Often patients are admitted to a community hospital following discharge from an acute NHS provider, for rehabilitation or other services.

132 For certain services, where consultants work across two (or more) NHS organisations, it may be that a patient is discharged from one NHS provider and admitted to another NHS provider without changing consultant. Although an FCE ends with discharge by a consultant, for the purposes of Reference Costs, an FCE also ends when patients are discharged from an existing NHS organisation (i.e. Legal entity) to a new NHS organisation, but not when patients are transferred between sites within a single NHS organisation. Note that data standards have always stipulated that if a patient transfers between organisations rather than sites, then the patient's hospital provider spell [and current consultant episode] ends.

133 Please note that patients may be admitted outside acute related pathways, in which case please report using the relevant HRG code (if possible).

134 Further details of how Community Hospitals should report Rehabilitation services can be found in Section 8 of this document.

Eye Services

135 Eye services are included in both reference costs and tariff. If the hospital prescribes a pair of glasses or contact lenses and the patient goes out to the high street optician for the product, the hospital will pick up the voucher cost, net off any income received by the patient and then include the final cost in their reference cost return.

136 The costs will be included within ophthalmology outpatients, or as part of the admitted patient care (Elective, Non Elective and Day Case) HRG, for the prescriptions that follow from care received as an admitted patient. When a patient is seen in an optometry clinic (including Low Visual Aids clinics), the hospital should net off any income received from the patient, add to the pool of all optometry costs and include in the reference cost return as ophthalmology outpatients, or as part of admitted patient care HRG.

Mental Health

137 More details on the costing of mental health services can be found in Section 13 of this guidance. Mental health services provided by specialist mental health service providers are not recorded using HRGs for reference costs purposes. Please note HRG4 Chapter WD (Mental Health HRGs) should be used by non-specialist Mental Health providers only.

Elderly Medicine

138 *Elderly medicine is provided in a number of different ways by NHS providers. For many elderly patients, an acute period of care also leads to a period of rehabilitation care, occasionally followed by long term inpatient care. In some places the acute and rehabilitation components may be delivered within the treatment function of general/integrated medicine, in other places it is split between general medicine*

and geriatrics. This means that it is not possible to distinguish between acute, rehabilitation and long stay care, on the basis of treatment function alone.

139 *4.14.2 For episodes discharged from the treatment function of geriatrics, costing should be undertaken using HRGs for the period of care up to the acute treatment function trim point for that HRG. How subsequent bed days should be costed and reported will vary, depending on the clinical reason for the stay past the trimpoint.*

140 *The excess bed days [those past the trimpoint] for patients in elderly medicine may have resulted from :*

- *Clinical factors meaning that the patient remains in hospital for a longer than expected length of time; or where a longer saty has resulted from medical complications, e.g. a diabetic patient requiring longer than average to heal after a hip replacement, should be costed and reported accordingly at excess bed day level. An example of costing days in excess of an expected length of stay that relate to rehabilitation, e.g. prolonged physiotherapy after a hip replacement, prior to discharge, can be found in section 8 of the 2010-11 Reference Cost Guidance.*

141 *Excess bed days in elderly medicine that have resulted from medical complications, e.g. a diabetic patient requiring longer than average to heal after a hip replacement, should be costed and reported accordingly at excess bed day level.*

142 *An example of costing days in excess of an expected length of stay that relate to rehabilitation, e.g. prolonged physiotherapy after a hip replacement, prior to discharge, can be found in section 8 of this guidance.*

Patients with Haemophilia

143 *Elective and non-elective inpatients, with the primary diagnosis for admission being haemophilia are will be output from the grouper under treatment function code 309 - Haemophilia . This allows the high costs associated with blood products to be identified to the relevant group of patients and will not distort the costs of other inpatients. Please note that some blood products are included within the unbundled High Cost Drugs HRG4s, therefore when specifically identified by these HRGs, the costs and should be reported separately from the admitted 'core' HRG.*

144 *Where the primary diagnosis is for another medical problem e.g. appendectomy, there is no change in the grouping hierarchy, and activity and costs will still be associated with the dominant treatment or procedure, including the costs of associated clotting products. This is a valid reason for cost variations, although it may involve only a small number of patients in any given year.*

145 *Separate categories appear for outpatient services requiring information at first and follow up level. This allows the costs of blood and other clotting products to be directly attributed to these clinics and reduce distortions elsewhere. This separation will continue to ensure that the previous cross subsidisation associated with these services remains removed. These changes do not impact on the treatment of costs for inpatient and other services.*

Spell Cost Collection

Introduction

146 **Following 2009/10 reference costs the Department ran a pilot collection of spells data with the support of several software suppliers and 10 volunteer NHS organisations. We are currently working to fully understand the outcomes of this collection (ie. whether the data collected is an appropriate basis for tariff calculation and the current spells guidance is suitably robust).**

The pilot collection proved to be a useful exercise and we are very grateful to those organisations that took part. From our initial understanding it is clear that we are not yet in a position to mandate the collection of spell level data for 2010-11, however we are looking to refine the methodology for the collection of this data. Work has begun around developing a

further non-mandatory pilot of spells on a larger scale following 2010-11 reference costs in order to provide sufficient information as to suitability of spell data as a basis for tariff. We will continue to work with the organisations and software suppliers who contributed to the 2009-10 spells pilot in order to refine the spells collection and make this as straight-forward an exercise as possible.

We expect to carry out a further non-mandatory collection of spells data and will be looking to a larger number of organisations to provide spell based reference cost data in 2010-11.

As in 2009-10 reference costs guidance, we encourage organisations to look towards reporting spell data as this may become a part of future reference costs collections in order to support the production of tariff.

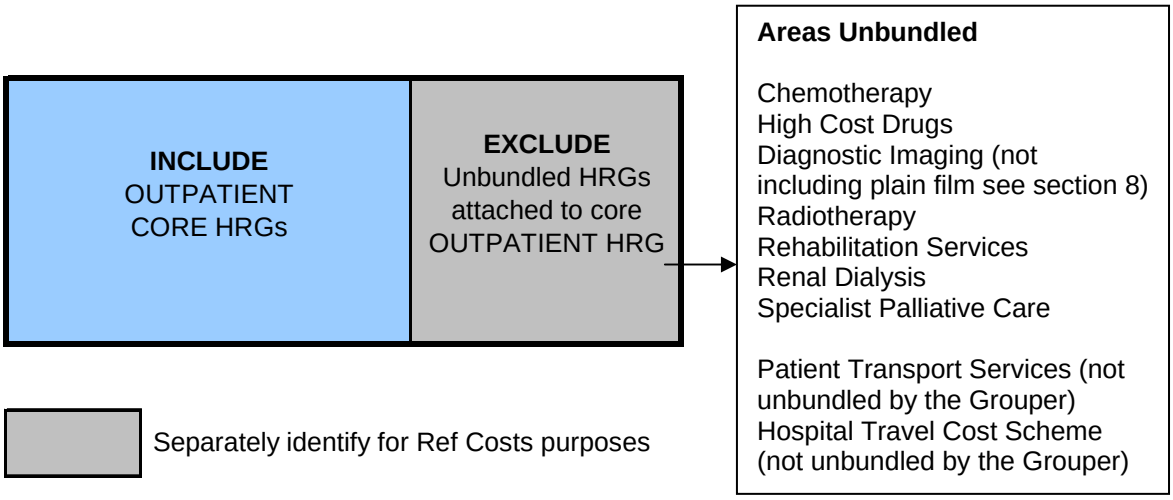
SECTION 3

OUTPATIENT SERVICES

Outpatient Services referred to in this section are:

Area	Currency for reporting	Paras	Unify2 Reporting Worksheet
Outpatient Attendances	Attendances, Consultant/Non Led, TFCs and HRG4	150-212	OP Attendances
Outpatient Procedures	HRG4	213-217	OP Procedures

147 Outpatient attendances and procedures should be reported using the latest HRG4 Categories. The output of the HRG4 Reference Cost Grouper will attach one or more unbundled HRGs to the core HRG produced. Please note, only cost and activity data for the **core HRGs** are to be reported within this section. Unbundled activity is to be reported separately (see Section 8 of this guidance):



148 The HRG4 categories designed to separately identify services from the outpatient services are listed below:

Service	Area reported in 2010-11 Ref Costs
Chemotherapy	(Services Separately Identified)
Radiotherapy	(Services Separately Identified)
Diagnostic Imaging (Radiology)	(Services Separately Identified)
Specialist Palliative Care	(Services Separately Identified)
High Cost Drugs	(Services Separately Identified)
Rehabilitation	(Services Separately Identified)
Renal Dialysis	(Services Separately Identified)

'Pre-booked' / Not 'Pre-booked'

149 If a patient attends a clinic without an appointment, this activity should be included within the outpatient section of the collection files. Cost and activity for **Ward Attenders is not reported separately**, instead reported here within outpatients (bundled back in) consistent with the calculation of tariff. Therefore, it is necessary to have a 'designated outpatient slot'.

OUTPATIENT ATTENDANCE

150 The 2010-11 Reference Cost collection continues to use the HRG4 categories for Outpatients. The 2010-11 HRG4 Reference Cost Grouper output contains HRGs that will split all outpatient attendance data by:

- First or Follow-up Attendance
- Uni or Multi-professional attendances
- Face-to-Face (or non) attendances

2010-11 Outpatient HRG4 Categories:

WF01A	Non-Admitted Face to Face Attendance - Follow-up
WF01B	Non-Admitted Face to Face Attendance – First
WF01C	Non-Admitted Non Face to Face Attendance - Follow-up
WF01D	Non-Admitted Non Face to Face Attendance – First
WF02A	Multiprofessional Non-Admitted Face to Face Attendance - Follow-up
WF02B	Multiprofessional Non-Admitted Face to Face Attendance – First
WF02C	Multiprofessional Non-Admitted Non Face to Face Attendance - Follow-up
WF02D	Multiprofessional Non-Admitted Non Face to Face Attendance – First

For further information on the logic behind the HRGs, please see the 'Code to Group Table' on the IC website and speak to coders within your organisation to see which activity would be coded to the relevant OPCS codes.

Procedures carried out in an outpatient setting will generate a core HRG that reflects that procedure (instead of a core attendance HRG).

The generation of one of the 'multiprofessional' HRGs is dependant on the recording of an OPCS code in the record that denotes a multiprofessional or multidisciplinary attendance, i.e. X62.2 Assessment by multi-professional team, X62.3 Assessment by multi-disciplinary team.

Multi-professional is defined as where multiple care professionals (including consultants) see a patient together, in the same attendance.

It does 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 recorded as such. It would not apply if one professional is simply supporting another, eg in the taking of notes.

*This is in line with Connecting for Health guidance on joint consultant clinics:
http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/help/faqs-07/sharedcare

151 The outpatient HRGs are generated using different but **mandated** fields in the Commissioning Data Set (CDS). There are fields in the CDS to indicate TFC, Attendance (First / Follow-up), Attendance (Face-to-Face / Non), and OPCS codes to indicate Attendance (Multi / Uni).

152 Due to the large number of outpatient attendances recorded in Trusts, there is a possibility that the activity (above) will not have been coded in 2010-11. As a result, the Grouper will fail to generate the specific HRG4. If this is the case then organisations should revert to methods used in previous years to identify activity/costs, using the definitions supplied by NHS Connecting for Health.

153 Organisations are advised to take steps to ensure they are in a position to code this data in the CDS to enable the future calculation of reference costs and calculation of tariff.

154 The 2010-11 reference costs collection continues to require mandatory unit cost and activity information:

- on a first and follow up attendance/contact basis;
- split by face to face (attendance) and non face to face (contact)

First / Follow-up Attendance

155 The definition of First Attendance is found in the NHS Data Dictionary **first attendance**.

156 From an NHS Data Dictionary perspective, a First Attendance is the first time a Patient has been seen by a Care Professional **for a series of appointments**. Follow-up Attendances are those that follow the First Attendance irrespective of whether the First Attendance may have taken place in a previous financial year.

157 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 as such.

158 Please note, under face-to-face activity, triage of paper referrals should be included as an overhead when a patient is seen – this is a way of preventing unnecessary appointments.

Face-to-Face and Non-Face-to-Face

159 The definition for a non Face-to-Face contact is clarified on page 4 (of 15) of **DSCN 32/2004** and is clarified in the paragraph below.

160 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.

161 Please note that 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.

162 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 (however, see paragraphs 202-212 for Cancer Multi-Disciplinary Teams which is the only exception).

163 Where organisations are unable to distinguish between face to face and non-face to face activity, **all** costs for a particular Treatment Function / service area / clinic function **should be reported as face-to-face activity only.**

164 As a general principle, it should be noted that the same patient could access a service as a face-to-face contact and as a 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 in 2010-11. Although some patients might be reported in both categories, not all would be expected to do so.

Consultant Led / Non-Consultant Led

165 The 2010-11 reference costs collection also requires outpatient attendance cost/activity data to be further disaggregated by Consultant Led and Non-Consultant Led activity:

Consultant Led

166 **Consultant Led** 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 he/she takes overall clinical responsibility for patient care.

167 For reference cost purposes, Consultant Led activity will take place in a consultant clinic, defined as per the **mandatory** Outpatient Attendance Commissioning Data Set (CDS) Type 020 Type using the CONSULTANT CODE data element and its default codes for NON-CONSULTANT activity as set out in the Out-Patient Commissioning Data Set and also the relevant MAIN SPECIALITY CODE and TREATMENT FUNCTION CODES as follows:

Consultant Out-Patient Episode - Person Group (Consultant):

Consultant Code	GMC / GDC Number C9999998 - Consultant, GMC number not known CD999998 - Dental Consultant: General Medical Council (GMC) number / General Dental Council (GDC) number not known
Main Specialty Code	As recorded on PAS
Treatment Function Code	As recorded on PAS

http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultant_code_de.asp?query=Consultant%20Code&rank=100&shownav=1

168 If GPSI clinics and those run by specialist therapists are classed as consultant led activity, they are normally taking patients from what would have been a consultant list.

Non-Consultant Led

169 Where the activity is not Consultant Led, the activity and costs should be reported separately from the consultant led activity.

170 **Non-Consultant Led** activity takes place in a clinic where the consultant is not in overall charge (i.e. anything not covered in paragraph 167 above). Again, these clinics are defined using the CONSULTANT CODE data element and its default codes for NON-CONSULTANT activity as set out in the Out-Patient Commissioning Data Set and also the relevant MAIN SPECIALITY CODE and TREATMENT FUNCTION CODES as follows:

Consultant Out-Patient Episode - Person Group (Consultant):

Consultant Code	M9999998 - Midwife N9999998 - Nurse H9999998 - Other health care professional D9999998 - Dentist, Dental Practice Board (DPB) number not known
Main Specialty Code	As recorded on PAS - Other health care professional
Treatment Function Code	As recorded on PAS - Other health care professional

171 **Non-Consultant Led activity** also includes activity that takes place in a Sexual and Reproductive Health Clinic (previously referred to as Family Planning Clinic). Please note that this CFH business definition is without codes. A more detailed definition of these clinics is found within the CFH Data Dictionary:

www.datadictionary.nhs.uk/

Outpatient Attendance Treatment Function Codes

172 The 2010-11 reference costs collection continues to require mandatory outpatient unit cost and activity information split by Treatment Function Code (listed in **Annex C** of this document).

Paediatric Treatment Function Codes (also applicable to Admitted Patient Care)

Specialist Children's Hospitals

173 Specialist children's hospital organisations should now have implemented the dedicated Paediatric Treatment Function Codes (introduced in DSCN 17/2005 April '06) and should allocate activity to these (TFCs).

174 It is assumed that a small number of patients over 18 can also be undergo care in specialist children's hospital organisations (including Learning Disabilities, Cystic Fibrosis, and Grown up Congenital Heart Disease), but this is not likely to be a material amount, and are likely to be as resource intensive as younger patients (rather than similar to adult patients). To simplify the activity process for these – all patients at these organisations should be reported under the Paediatric TFC.

175 To clarify, additional patients in discrete paediatric clinics that are over 18 (materially small in number) have similar resource use to children rather than adults and should be reported under the relevant Paediatric TFC.

Non-specialist Children's Hospitals

176 The majority of clinics can be identified discreetly as either adult or child. However, where non-specialist ('non-dedicated) Paediatric Trusts are unable to identify the exact services provided for children they should **not report** these against the Paediatric TFCs.

177 To clarify, where a consultant controls both adult and child clinics (i.e. it is not possible to identify every patient to the TFC of their consultant) and the PAS restricts a single TFC code per clinic, please report against the relevant non-Paediatric Treatment Function under which the patient is treated.

178 For the longer term development of PbR (payment and strategy), all organisations are advised to work towards recording all paediatric work under the relevant Paediatric TFC on their PAS.

Community Paediatrician Treatment Function

179 As per previous years, please note that for **reference cost reporting**, cost and activity data clinically coded to TFC 290 (Community Paediatricians) **should not be reported against in this section,** instead, these costs/activity should be reported as Community (see section 6). This is in line with the decision to remove the 'pre-booked' element of the outpatients definition.

180 For clarification, activity (and costs) reported against TFC 291 (Paediatric Neuro-Disability) should include all neurodevelopmental conditions, not just neurological ones, and would include behavioural problems in this category. This avoids confusion about where, for example, autism/ADHD should be included. Where general paediatric patients are seen in community paediatric clinics, it is recognised that it may not be possible to separate these from neurodisability patients. However where a community paediatrician does a separate general paediatric clinic, these should be recorded under 420 Paediatrics. Multidisciplinary assessments including CDC assessments should be recorded under 291 as multiprofessional face-to-face contacts.

181 Please note that where neurodisability work conducted by community paediatricians is recorded, this should all be reported **(for reference cost purposes)** under TFC 291 and not in TFC 290 or the Community section 290 / CP60 i.e. in this instance it is the treatment function that matters, not what type of specialist delivers it. (Neurodisability has only just been recognised as a separate specialty so the majority of neurodisability work will continue to be done by community paediatricians for the near future).

Transplantation Outpatients

182 The HRG4 Reference Cost Grouper will produce outpatient HRG4 data if the relevant OPCS (not ICD) codes are fed into the grouper via the patient record. To confirm, if the conditions to generate a procedure driven HRG are met from the contents of the Outpatient dataset, the grouper will produce a HRG4 core procedure HRG.

183 If not, the de-minimus level of detail that the grouper produces will be either a HRG 'specific to non-admitted consultation' or the 'default' Outpatient HRG, either of which will need to be reported against the relevant transplantation Treatment Function Code.

Audiological Medicine

184 Note that the costs and activity associated with maintenance and reprogramming after implementation of Cochlear Implants and Bone Anchored Hearing Aids are excluded from Reference Costs in 2010-11. The costs and activity associated with **implanting** such devices continues to form part of the **admitted patient care** return (also listed devices are required to be reported separately in **Statement Z** – see Annex B). Please see section 10 for more on Audiology Services.

Cystic Fibrosis

185 Cystic Fibrosis services were separately identified for the first time in 2002/03, facilitated by the national specialised service definitions for Cystic Fibrosis. The 3 categories (Band 1, 2 and Other), split by adult/child that formed previous years' outpatient collections have been retained as detailed above.

186 The definitions for Band 1 and Band 2 are as follows: -

- Band 1
  Patients who come only to outpatients, receive outpatient care in terms of input from physiotherapist, doctors, social workers, dieticians, etc. [this may in exceptional circumstances include IP/DC – not for antibiotics]

- Band 2
  Patients who receive the above and in addition receive outpatient intravenous antibiotics 3-4 times a year. They may be occasionally admitted. The input as an outpatient may be more intense.

187 The HRGs are not in line with the outpatient data collected for reference costs and therefore **have been removed from the data collection**. Instead the data should continue to be reported at the Band level above.

188 The split between children (up to and including 18) and adults has been retained for Outpatient Cystic Fibrosis services for consistency with last year's collection.

189 Further details of the requirements for reporting **Ordinary Admission (Elective or Non-Elective)** Cystic Fibrosis data can be found in Section 5 – Specialised Services.

190 Where organisations are **unable** to distinguish between child (up to and including 18) and adult activity for cystic fibrosis, they should continue to report all outpatient activity and cost data in the equivalent adult Treatment Function, split, as appropriate, between first and follow up attendances.

HIV / Aids

191 Detailed costing of these services has already been undertaken in the NHS as part of previous reviews of funding. The introduction of a separate analysis of these services in 2000-01 built on this work. There is no change in approach for services provided to patients with a secondary diagnosis of HIV/Aids.

192 The costs associated with outpatient services need to be separately identified - treatments associated with combination drug therapy for example, need to be directly attributed to these services to prevent distortions elsewhere. A separate category within outpatients was introduced in 2000-01 and will continue to be collected in the same format. Cost and total attendance data should be reported using the **follow up attendance category only**, to protect patient confidentiality.

Radiotherapy

193 Some patients attend radiotherapy clinics, and do not have any form of radiotherapy treatment covered by the radiotherapy HRGs. These are therefore outpatient appointments that can be classified as Consultant-Led in line with current definitions. Where a radiotherapy treatment is undertaken (regardless of setting), the radiotherapy costs still fall into the relevant radiotherapy HRG category. Where no treatment occurs, organisations should report as normal outpatient activity. These attendances to see a relevant clinical professional are therefore included at first and follow up level. This is consistent with the approach adopted in previous years.

Therapy Services

194 Occupational Therapy, Physiotherapy and Speech and Language Therapy attendances at outpatient clinics were recognised as new Treatment Functions from 1st April 2006. These categories are to be used in instances where referral for treatment carried out has been made by a clinical / other professional, including a GP, or self-referral, and where the patient attends a discrete therapy clinic solely for the purpose of receiving therapy treatment. Referrals by GPs to such clinic-based services are not required to be separately reported as direct access therapy. (Section 9 clarifies).

195 As with other types of support services and care, where these services form part of an Admitted Patient Care (Elective, Non Elective and Day Case) episode, their costs are included as part of the overall treatment cost. Similarly, where the treatment is included as part of an outpatient attendance, in a separate specialty, the costs will form part of the composite costs of that outpatient attendance.

196 The split between children (up to and including 18) and adults has been retained for therapy services for consistency with last year's collection as this data will not be captured by the new Paediatric TFCs. Please report Child Therapy activity as that taking place in a Child-Only Clinic i.e. it is the therapy provided that matters, not who receives it.

197 Note that details regarding the number and total cost of clinics (sessions) run on a group basis will continue to be required for **Statement Z** in 2010-11.

Podiatry (653)

198 These services should be reported on line '653 Podiatry' where patients attend a podiatry clinic **solely for the purpose of podiatry treatment**.

Dietetics (654)

199 These services should be reported on line '654 Dietetics' where patients attend a dietetic clinic **solely for the purpose of dietetic treatment**. Referrals by GPs to such clinic-based services no longer need to be separately reported (Section 9 clarifies).

The split between children (up to and including 18) and adults for Dietetics is standard for reference costs purposes.

Orthoptics (655)

Where Orthoptic clinics are operated as a **discrete** and separate service from Ophthalmology clinics, these should be identified under the '655 Orthoptics' Treatment Function in outpatients at first and follow up level. Where orthoptists, optometrists or other clinical professionals provide services as part of an overall Ophthalmology service, these costs should continue to form part of the cost base for the Ophthalmology service.

Genetics (311 – Clinical Genetics / 312 – Clinical Cytogenetics and Molecular Genetics)

200 **For 2010-11 data should only be submitted against TFCs 311 and 312 (as appropriate) where a consultant/non-consultant led episode takes place for the purposes of a genetics attendance. For 2010-11 reference costs data should be reported using the WF01A- WF01D HRG codes in the Outpatient Attendance sheet of the REFC workbook. Include the costs of any tests requested as part of the outpatient attendance.**

201 **Please note that where genetics services are used to support other services (such as APC patient episodes) the costs of the genetics tests should be factored in as an overhead to the core HRG in line with full absorption costing principles and should not be reported under the genetics TFC.**

Cancer Multi-Disciplinary Teams (CMDTs)

202 There is only one exception to the face-to-face rule in paragraph 159–164 and this is for specific Cancer MDTs meeting to discuss a patient. For the 2010-11 Reference Costs, CMDT reporting codes exist for five specific areas.

Cancer MDTs have been defined by NICE as essential to the delivery of high quality cancer care. Although currently outside the scope of tariff, their costs may be built into a specific cancer outpatient tariff and therefore an improved understanding of MDT costs is essential.

203 **As per the 2009-10 collection, the data is collected across the 5 areas against 5 separate CMDT 'TFCs'. This is in line with the Cancer Network Directors and Cancer Action Teams recommendation that a sample of the most established MDTs (with good levels of membership) should initially be costed rather than all MDTs. For 2010-11 reference costs purposes, where possible organisations should cost the following MDTs:**

- **Colorectal MDT meetings**
- **Local Gynae MDT meetings**
- **Specialist Gynae MDT meetings**
- **Breast MDT meetings**
- **Specialist UGI MDT meetings**

<u>A definition of CMDTs</u>

204 Cancer MDTs do not take place instead of outpatient activity, but in addition to it. 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.

205 The multi disciplinary team meetings bring together representatives from different healthcare disciplines on a formal timetabled basis to discuss all 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.

How to cost the CMDTs (and derive activity data)

206 The following methodology provides organisations with a suggested approach to costing and recording the activity:

Start by making contact with the Cancer Services Manager for each of the above CMDTs to determine:

- the number of MDTs;
- the duration of a MDT meeting;
- the number of individual patient care/ treatment plans developed for meetings;
- the frequency of a MDT meeting (e.g. once per week, once per fortnight); and
- the staff involved in each MDT.

Apportion consultant costs as per their job descriptions (this data could be available from either Financial Management or Consultant job plans/sessional information could be used to help apportion the costs);

The costs of support staff used in preparation/follow-up of meeting e.g. in pathology, medical records department etc should be apportioned. Cancer Services Managers should be able to help identify where the costs of the MDT co-ordinators (who were admin and clerical) were coded as they are responsible for such staff.

The cost of any data collection should also be included;

The above guidelines are one-approach to obtaining the data and there may be other, equally valid ways of doing so which can be used.

Reporting CMDTs for the Reference Costs submission

207 The currency recorded should be the **individual patient care / treatment plan** for each of the above MDTs as this is the 'product' of the CMDTs e.g. 1 unit = 1 patient treatment plan discussed, 2 units = 2 patient treatment plans discussed, and so on.

208 CMDTs will always have a defined consultant lead, who is responsible for chairing the meeting, ensuring treatment decisions are recorded etc. Therefore, CMDT cost and activity data should be reported on the relevant **Consultant Led - first attendance** reporting line in the reference cost collection broken down by CMDT type – always as **'non-face-to-face'**

209 **MDTs where activity and cost can be identified should be reported separately using the appropriate 'CMDT' TFC as below:**

- **Colorectal MDT meetings** **CMDT_C**
- **Local Gynae MDT meetings** **CMDT_LG**
- **Specialist Gynae MDT meetings** **CMDT_SpG**
- **Breast MDT meetings** **CMDT_B**
- **Specialist UGI meetings** **CMDT_SpU**

The costs of any other MDTs should be included as part of the overhead costs associated with providing the cancer treatment / care.

210 **In the event that organisations are unable to record the CMDT activity and unit cost at each of the 5 CMTS listed above then please report an estimate of the annual 'total' cost of each individual MDT mentioned above against the appropriate TCMDT TFC (with an activity of 1) as below:**

- **TCMDT_C = total cost of Colorectal MDT meetings**
- **TCMDT_LG = total cost of Local Gynae MDT meetings**
- **TCMDT_SpG = total cost of Specialist Gynae MDT meetings**
- **TCMDT_B = total cost of Breast MDT meetings**
- **TCMDT_SpU = total cost of Specialist UGI MDT meetings**

211 Alternatively, where organisations are **unable to record the** annual 'total' cost of each individual MDT mentioned above, one further line is available in the collection file (**TCMDT** – Total Cancer Multi-Disciplinary Teams) where NHS providers can report an estimate of the **annual 'aggregated total' cost of the 5 individual MDTs against the TCMDT TFC (with an acticity of 1) as below:**

- **TCMDT = aggregated total cost of the 5 MDT Meetings (above)**

Responsibility for CMDTs costs

212 Although an MDT may draw on membership from several trusts, there must be a **clear host organisation** responsible for the MDT running and **this organisation** should report the reference costs.

Where sufficient financial governance arrangements are not in place (e.g. recharging arrangements), then an adjustment to the reference cost quantum may be required to take account of costs that do not appear in the organisation's accounts.

Please note that it **should be possible for organisations to begin preliminary investigations as to how to obtain MDT information immediately i.e. in advance of the reference cost submission.**

As these 5 MDT meetings are reported separately for Reference Cost purposes i.e. costs excluded from the core HRG, they will not be within the scope of the 2013/14 national tariff.

OUTPATIENT PROCEDURES

213 Organisations **must** report activity/costs for outpatient procedures in their Reference Cost return using the HRG4 categories. HRG4 categories have been developed to assign outpatient records that include a procedure code to the relevant HRG. There is no requirement to split procedure activity between child and adult in this first instance (unless there is an age specific HRG), nor to distinguish between procedures carried out in a first attendance, and those carried out at a follow up attendance.

214 **Note that where an outpatient procedure is reported, an outpatient attendance (either first or follow up) cannot also be counted for this same activity.**

215 All surgical HRGs have been shown for consistency, however, it is recognised that not all will be carried out as outpatient attendances. The Outpatient procedures can be grouped to HRGs using the Information Centre HRG4 Reference Cost Grouper and be reported against the relevant HRG. For the grouping of Outpatient data, it is not essential that a primary diagnosis is recorded to determine the HRG.

216 Where organisations are unable to separately identify procedures undertaken in an outpatient setting, they should report this outpatient activity data using first and follow up attendance categories, split between adult and child (Dietetics and Cystic Fibrosis only), and as face-to-face as appropriate. Organisations are advised to ensure that the ability to separately identify procedures undertaken in an outpatient setting is available in future years.

217 A list of OPCS codes that map to the HRG4 categories are available in the 'Code to Group Table' at the Information Centre website, to aid consistency in data reporting. The documentation output shows each HRG and the codes (both OPCS and ICD10) that may end up in that HRG. These can be found on the website

http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/costing

The 'Code to Group' can be accessed via the link for Grouper Documentation.

The Code to Group table shows, in spreadsheet form, how each OPCS code and ICD10 code maps to HRGs - including all logic as denoted by flags. This can be found beneath "HRG4 Definitions" at the same web address.

Outpatient Activity

218 For 2010-11, where a patient sees a health care professional in an outpatient clinic setting, and that patient receives healthcare treatment, including an attendance .such activity can be counted as valid outpatient activity. Note that healthcare professionals are those that provide clinical or medical treatment and are employed by an NHS provider. This definition is in line with CFH data dictionary definitions.

219 When a patient has two separate attendances at 2 separate clinics can the activity be counted separately. 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 as such. Please refer to paragraph 150 for more on multi-professional / multi-disciplinary.

220 All such clinics are included in the exercise where the activity, costs and income are counted against the service agreement with the NHS provider. This includes clinics held in a variety of locations and not just those held within main hospital sites, thereby including GP practice premises.

Where a clinician or nurse holds outpatient clinics whilst acting in a private capacity, these are not recorded against the NHS organisations activity and cost base and therefore are excluded from the exercise from a provider perspective. The same 'rules' apply to outpatient clinics held by a clinician or other primary care practitioner as part of the plus element of a PMS contract.

221 *The standard approach to the costing of outpatient activity remains unchanged. When producing unit attendance costs at Treatment Function or service level, the costs of investigations, tests, drugs or other care, 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****. Examples include:-*

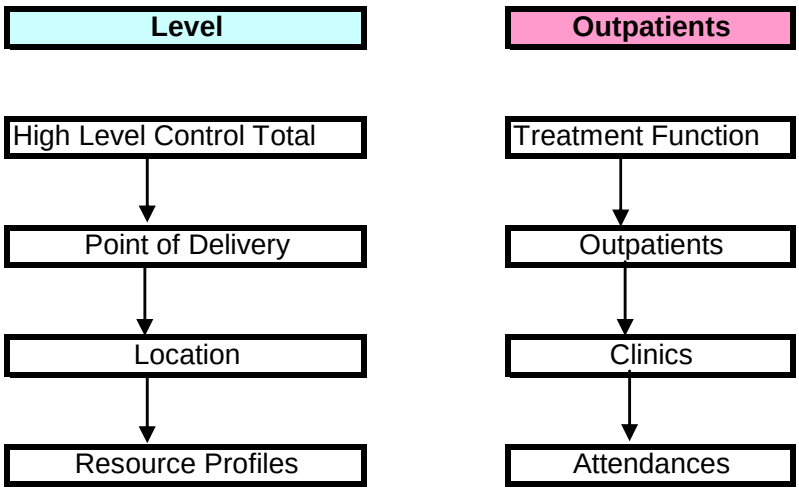
- *A patient attending an outpatient clinic, followed by six physiotherapy attendances, (in a discrete physiotherapy clinic, where the patient attends solely for the purpose of receiving physiotherapy treatment) before a follow up outpatient appointment is reported as two outpatient attendances (first and follow up in relevant specialty), and six physiotherapy attendances in the outpatient physiotherapy category (650). If the consultant stays the same for the first physiotherapy attendance, we suggest you record it as the follow-up; where as if the consultant changes, record it as a first attendance and so on.*

222 *For costing outpatient activity at treatment function, sub-treatment function or service level, the costs of investigations, tests, drugs or other care that are not unbundled, (see section 8 of this guidance), should be included at the point of commitment, up to the point where the patient accesses another service that is separately reported in reference costs.*

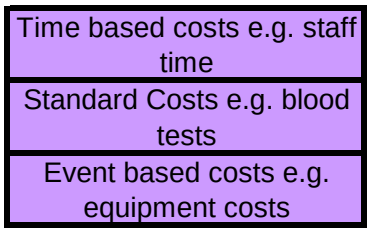
223 *For example, in some organisations all tests etc. are provided as part of a first outpatient attendance (in effect a one-stop service). In other organisations, patients return for blood tests etc. at their convenience or on an appointment basis, prior to a follow up outpatient appointment. In both circumstances, the costs of all tests and supplementary care should be reported as part of the first outpatient attendance only, as they are generally completed prior to a subsequent (follow up) outpatient attendance.*

Costing Outpatient Approach

224 *The costing approach used for the costing of outpatients is consistent with that used for inpatients and day cases.*



The costs will fall into 3 categories:



Each of these cost categories is discussed in detail below.

Time Based Costs

225 *For outpatients, this will relate primarily to staff time. The options available for the allocation of staff time are:*

- patient related time; or
- total time

226 *Total time would allow the identification of all staff time, including the time that was allocated to patients that failed to attend for their outpatient appointment (DNAs). Many NHS providers have already adopted a policy of 'overbooking' outpatient clinics to allow for DNAs and to ensure that the productive time in outpatients is maximised.*

227 *Whilst the level of DNAs is a significant managerial issue in some areas, for the purposes of reference costs, staff time and the costs associated with DNAs, should be treated as an overhead on patient related time. (For the treatment of DNAs in mental health, please see Chapter 9 on Costing Mental Health Services).*

228 *Staff costs should therefore be allocated on the basis of patient related time analysis. This will provide a consistent basis for costing of this element of outpatient costs. Only if this cannot be done, should total time be used.*

229 *It is acknowledged that detailed time analysis of the proportion of staff time spent on outpatient procedure related activities will not be readily available at this level. Where no duration is available, medical input will be required. Clinical and nursing estimates of the varying levels of input by staff should be used to support the development of relevant resource profiles for outpatient procedures. These estimates should be consistent with the accounting principle of prudence and the standard practice for the allocation and apportionment of overheads detailed in Appendix 2 of the Costing Manual.*

Attributing Standard Costs

230 *This section covers other direct costs which can be attributed to resource profiles on the basis of standard costs. This is linked with the allocation of relevant costs at the time they are committed rather then the time they may actually be delivered. This is due to the different methods of delivery used by NHS providers. Some operate a 'one stop' system where all tests are carried out within the clinic itself whilst others set appointments for patients to return at a later point to access the various tests requested.*

231 *The costs, where not unbundled, which should be allocated to resource profiles in this way include:*

- *pathology costs*
- *equipment costs (where these can be directly attributed to the individual*
- *profile of care)*
- *other care (including any therapy-based care required as part of the attendance).*

232 *Standard costs for specialist equipment and these services are already produced for use as part of internal charging systems within NHS providers and are now to be applied to attendance based costing for outpatient clinics.*

Event Based Costs

233 *It is not appropriate to allocate some costs directly to specific groupings as they relate to the event as a whole i.e. costs relate to the clinic rather than individual elements within it.*

234 *These costs should be identified and allocated and apportioned to the clinics as overheads. The methodology used should be consistent with Appendix 2 of the Costing Manual.*

Costs of Fixed Assets

235 *Capital charges can have a significant impact on the cost of outpatients. This is influenced by the location in which the clinic is held. All clinics which are consultant led or non consultant led are included at this point. This is consistent with the costing principle of reference costs providing the costs of NHS services to NHS patients.*

236 *Increasingly NHS providers are offering outpatient clinics in a variety of settings and where these clinics are operated by the NHS provider, and the associated activity and costs relate to service agreements, then these should be included in the exercise. This includes clinics that may be held outside a central department and provided in other premises which may / may not be owned by the NHS provider. If outpatient clinics are held by consultants acting in a private capacity, and are not part of the NHS*

provider's income stream, then these are excluded (see section 16 of the latest Reference Cost Guidance for a list of exclusions).

237 *The production of outpatient attendance costs by location may be significant for a NHS provider's internal management as costs may vary. For reference cost purposes however, the outpatient attendances should be reported on an organisation wide basis as for inpatient and day case activity. Even where internal management consider separate sites as entities in their own right, the entire NHS provider is the recognised reporting unit for central returns and reference costs comply with this approach.*

238 *The use of equipment in outpatient clinics and for treatments and procedures undertaken in outpatients, needs to be included in the total quantum of costs for reference costs, and this cost needs to be attributed to outpatients on a consistent basis as used for inpatient and daycase activity. Some equipment may be apportioned directly to individual treatments (see section 6.7 above) e.g. lasers for the treatment of some dermatology cases. General equipment may also be used, and these will need to be allocated to the clinic and apportioned to the resource profiles as an overhead.*

239 *In allocating equipment costs two methods are acceptable:*

- cost per minute
- cost per use

Most NHS providers already use one of these methods and currently this is left to local discretion as to which is most appropriate. Given the wide range of equipment in use in NHS providers, both methods may be used dependent on the different types of equipment. No other methods of apportionment or allocation are to be used for the costing of NHS services, other than the two specified.

Overhead Costs

240 *Outpatient costs will also include the relevant level of overheads. These fall into two main categories:*

- clinic/ treatment function/ location specific
- NHS organisation wide.

241 *The clinic/treatment function/location specific costs should be apportioned in line with the guidance included in this chapter and the guidance contained in Appendix 2 of this Costing Manual.*

242 *Outpatients will also bear an element of NHS provider overheads including human resources, finance etc. The apportionment of these costs should be consistent across the organisation and points of delivery within specialties. The general guidance on this is contained in Appendix 2 of this Costing Manual.*

Summary

243 *The main points to be considered when undertaking costing of outpatient attendances at procedure level are:*

- Annualised figures should be reported for activity and unit costs.
- Outpatient procedures should be reported separately, where required. Where an outpatient procedure is reported, an outpatient attendance (either first or follow up) cannot also be counted for this same activity. Where organisations are unable to separately identify outpatient procedures undertaken, they should report all outpatient activity data using first and follow up attendance categories, split between adult and child, where appropriate.
- All clinics should be included regardless of location.
- Costs should be included when committed.

- Costs should be split based on:
    - time related costs
    - standard costs
    - event based costs
- Representative medical estimates of patient related staff time are acceptable.
- Standard costs to be used for some direct costs e.g. pathology.
- Direct costs to include costs of associated therapy care.
- Equipment costs should be allocated on a cost per use or cost per minute basis, as best reflects local practice.
- All relevant overheads should be included; this covers clinic/location/ treatment function overheads in addition to an element of NHS provider wide overheads.

Alternative Service Delivery

244 Following moves towards regulation of a range of therapists, it seems appropriate to clarify the costing guidance in this area. Where therapists and practitioners such as chiropractors, acupuncturists, aromatherapists and other complementary practitioners form part of a team providing a range of services, for example, in orthopaedics, pain management, their costs (and related on-costs) should be included in the respective cost pools. This approach is consistent with the principles of full absorption costing and matching costs to the services that generate them

245 Where services provided by these practitioners are discrete services / clinics, e.g. aromatherapy, massage, acupuncture, homeopathy, **these services continue to be excluded in 2010-11**.

Mental Health

246 Details on the costing of Mental Health outpatient (and community) appointments can be found in Section 13 of this guidance.

SECTION 4

ACCIDENT & EMERGENCY MEDICINE
(INCLUDING MINOR INJURY SERVICES, CASUALTY UNITS, WALK IN CENTRES)

Accident and Emergency services should include:

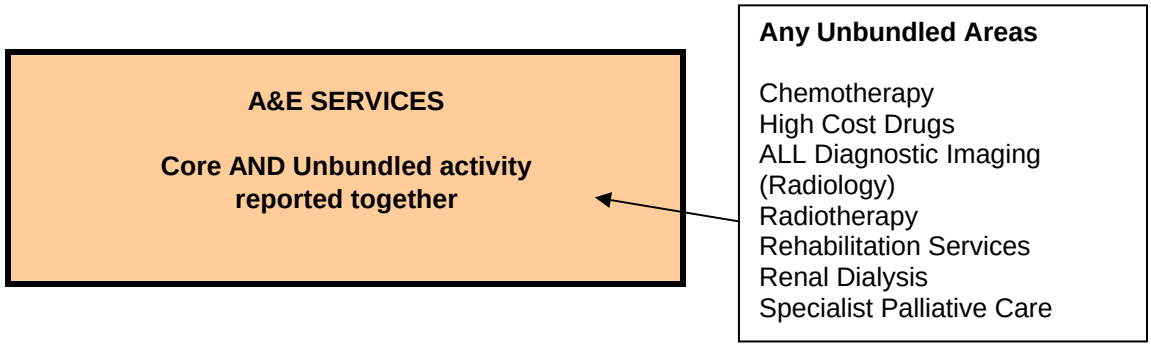
Area	Currency for reporting	Paras	Unify2 Reporting Worksheet
24hr A&E services	Attendances and HRG4	256-261	A&E
Minor Injuries Units	Attendances and HRG4	263-267	A&E
Non24hr A&E services	Attendances and HRG4	263	A&E
Walk in Centres	Attendances and HRG4	268	A&E

247 The 2010-11 Reference Cost collection covers all services that fall within the sphere of Emergency & Urgent Care Services, **as defined by the design of the HRGs** (see IC website). Please note that activity by Mental Health Liaison services should not be included in A&E activity, as this is covered in the Mental Health Specialist Teams collection.

248 In A&E, the unbundled activity discussed in section 8 of this guidance is effectively included in the logic for generating the A&E HRG, so separate unbundled HRGs will never be generated for A&E by the HRG4 Reference Cost Grouper. The costs of activity typically 'unbundled' therefore should be **included** within the A&E core HRGs.

249 Therefore, people using the A&E MDS to feed the organisation's PAS, and thus the Grouper, should not report any of the unbundled activity and costs (reported in section 8) separately, they should all be included within the A&E costs.

250 Those people not using the Grouper (i.e. not coded activity correctly) should apportion the relevant activity/costs for such support services to A&E. This is shown in the diagram below:



251 All NHS organisations should now have implemented the A&E minimum dataset (MDS), mandated from 1st October 2006. This data should be used to report your reference costs in 2010-11. The total activity for the 2010-11 financial year should be used and applied to the casemix groupings. You do have the option to 'Flex' the Casemix if you have better information available e.g. local systems mapped to HRGs.

252 If you have not implemented the mandated A&E MDS on 1st October 2006, then you may need to use local information systems.

253 Accident and Emergency services are defined as per the NHS Connecting for Health (CFH) Data Dictionary. New data requirements for A&E were mandated from 1 October 2006, in DSCN 05/2006.

Accident & Emergency Departments (all A&E services)

254 The Unit of activity for Emergency and Urgent Care HRGs and the unit of activity we would like reporting for reference costs are as Table 4:

Table 4: A&E Reporting

Setting	Emergency and Urgent Care HRG4s	Unit for Grouper Output	Unit Reference Costs reporting
All A&E settings	VB01 to VB11Z	Attendance	Attendance
All A&E settings	DOA	N/A	Attendance (for consistency)

OPCS coding used to produce A&E HRGs can be found on the Information Centre's website.

255 HRG4 categories for all A&E services are listed below:

Table 5: A&E HRG4 categories

Emergency and Urgent Care HRG	HRG Label
VB01Z	Any investigation with category 5 treatment
VB02Z	Category 3 investigation with category 4 treatment
VB03Z	Category 3 investigation with category 1-3 treatment
VB04Z	Category 2 investigation with category 4 treatment
VB05Z	Category 2 investigation with category 3 treatment
VB06Z	Category 1 investigation with category 3-4 treatment
VB07Z	Category 2 investigation with category 2 treatment
VB08Z	Category 2 investigation with category 1 treatment
VB09Z	Category 1 investigation with category 1-2 treatment
VB10Z	Dental Care
VB11Z	No investigation with no significant treatment
DOA *(not a HRG4 code)*	Dead on Arrival

For further information around Emergency and Urgent Care HRGs please see the FAQ on the IC website ((please see page 14 of 30 on IC website for A&E FAQs)

www.ic.nhs.uk/webfiles/Services/casemix/Roadshows/2009_HRG4_Roadshow_Questions.pdf

For information on the A&E HRGs, please click the link below
http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/archive/chapter-vb--emergency-and-urgent-care-code-to-group-table

24hr A&E services

256 24hr A&E activity (and all other A&E services) needs to be split by:

- patients that go on to be admitted (i.e. not discharged direct from A&E e.g. a patient that subsequently requires further treatment/observation and admission to a ward (including an Observation Ward that may be within the A&E dept)) and;

- Patients that do not go on to be admitted (i.e. patients that are discharged or die **whilst in A&E** e.g. injuries/ailments that can be treated within A&E and do not require an Ordinary Admission (Elective or Non-Elective) stay directly following the A&E attendance.

257 Every effort should be made to split the activity by the above categories:
- by using the attendance outcome produced by systems; or
- by using a 'Discharge Method Codes', or
- through the use of sampling or mapping local recording to HRG codes.

However, if you are unable to do so, then report all activity as 'not leading to admitted' activity by the relevant A&E service type.

258 If you cannot use the HRG4 Reference Costs Grouper to prepare your A&E Reference Costs data, every effort should still be made to report by specific HRG4 categories.

259 The A&E MDS was only mandated for 24hr A&E services, so you may need to follow this approach for each of the non-24hr A&E services.

260 In reference costs, cost and activity data should be reported separately depending upon the service provided by the relevant department. These are defined as below:

A classification of ACCIDENT AND EMERGENCY DEPARTMENTS according to the service provided.

Classification:
- A CONSULTANT led service with full resuscitation facilities and designated accommodation for the reception of accident and emergency PATIENTS
- A single SPECIALTY accident and emergency service (eg paediatrics, ophthalmology, dental) with designated accommodation for the reception of PATIENTS
- Other type of A&E/minor injury service with designated accommodation for the reception of accident and emergency PATIENTS
- NHS walk in centres

261 24 hour manned Accident and Emergency Units, whether single or multi-specialty, should be costed using the **'Emergency and Urgent Care' HRG4 categories** (split between being admitted to the hospital and not admitted).

Dead on Arrival (DoA)

262 Situations do occur when patients are brought to the A&E Departments by ambulance and the patient is Dead on Arrival (DoA). These patients have to be certified as dead by a clinician. These form a distinct category from those patients that die in an A&E Department. The cost and activity of such patients need to be included within the Reference Cost collection against the DOA collection line (note - not a HRG4 category).

Minor Injuries Units / Casualty / Non-24-hour Accident & Emergency Services / Walk In Centres

263 Attendances for each of the categories should be costed using the **'Emergency and Urgent Care' HRG4 categories** (split between being admitted to the hospital and not admitted).

Discrete Minor Injuries Units

264 To clarify, if patients are assessed at a single point in A&E, then classed as 'minor injury' (and subsequently seen with the MIU), all attendances should be recorded on the A&E system. In these circumstances, there should never be instances where there is MIU activity and no A&E activity, and this should **not be double counted** (all recorded in A&E).

265 MIU activity should be only be recorded separately if:

- The MIU ward is discrete and the attendance is instead of the A&E attendance and the activity/attendance has not already been counted as an A&E attendance; or

- The MIU is not discrete but patients are seen independently of the main A&E department, and recorded (and costed) separately.

266 As with all other services, the full costs of these services should be included. This will include costs of doctors, salaried GPs, as well as the costs of nursing, equipment, support services etc. The same requirement to distinguish investigations, treatments, admitted and non-admitted as with A&E departments is required for these units.

267 Where Minor Injuries Units are not discrete departments, but form part of an A&E department, the **costs** of such units should be included as an on-cost onto the A&E department itself, rather than being separately reported. Any separate MIU **activity that is collected should be excluded from the reference costs return** to avoid an artificial reduction in the average unit costs of A&E attendances. This treatment is in line with that of previous years.

Walk In Centres

268 In response to changes in clinical practice, discrete Walk In Centres were included in the Reference Costs 2004/05 collection for the first time. Walk In Centres provide:

- Information and treatment for minor injuries and illnesses such as strains and sprains, coughs, colds and flu-like symptoms;
- Instant access to health advice and information on other local services, such as out of hours GP and dental services and local pharmacy services.

As in previous years, the cost and activity data is required to be collected using HRG4.

Community Providers

269 Please note, Community Providers should currently report both MIU and WIC activity within the A&E reporting worksheet of the Reference Cost collection, although the **PbR Team are reviewing this area for Community Providers for the 2010-11 collection**.

SECTION 5

SPECIALIST SERVICES

Specialist Services included within this chapter are:

Area	Currency for reporting	Paras	Unify2 Reporting Worksheet
Adult Critical Care	Bed days, Critical Care Periods and HRG4 (Total No. organs supported), further disaggregated by CC unit + Burns and Spinal Injuries Unit	270-285	SSS – Adult Critical Care
Outreach Services	Total Cost (no activity)	286-287	New
Paediatric Critical Care	Bed days and HRG4	288-290	SSS – Paed & Neo
Neonatal Critical Care	Bed days and HRG4	291-294	SSS – Paed & Neo
Coronary Care Units	Bed days	295-296	SSS – CCU
Cystic Fibrosis Ordinary Admissions (Elective or Non-Elective) Bands 2-4	FCEs	297-306	SSS – Cystic Fibrosis
Cystic Fibrosis Ordinary Admissions (Elective or Non-Elective) Band 5	Bed days	297-306	SSS – Cystic Fibrosis Band 5
Hospital at Home / Early Discharge	Team Contacts and 'packages of care'. Disaggregated by COPD, Fractured Neck of Femur and Other	307-316	SSS - HAH
Home Delivery of Drugs	Home Delivery of Drugs	317-319	MPSZ (Rec Statement)

Adult Critical Care Services

270 The Critical Care minimum dataset (CCMDS) is a sub-set of the Admitted Patient Care (APC) dataset. A patient that is admitted to a Critical Care unit will have an APC 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. All unbundled HRGs (see section 8), whether derived from activity while the patient is in the critical care unit or on an Ordinary Admission ward, must be separately costed and reported for Reference Cost purposes.

271 Costs associated with critical care services are high and only relate to a limited number of patients. Where these costs are included as an overhead on treatments and procedures they significantly distort costs and lead to wide variations.

272 In line with DSCN 1/2005, issued in November 2005 (mandated from 1 April 2006), Adult Critical Care HRGs are now based on the total number of organs supported in a critical care period. Research work that was undertaken to develop the HRGs (carried out by the University of Sheffield) established that the total number of, rather than the type of, organ was the best way of grouping patients to produce HRGs that reflect relative resource use.

273 The CCMDS (DSCN 13/2005 refers) collects a wider range of organ support information. The Reference Costs collection in 2010-11 continues to employ these organ support categories in order to classify cost and activity data. Please note, that from 1 April 2009, DSCN25/2008 supersedes CCMDS.

274 To maintain consistency in approach therefore, the costs and associated activity for stays in critical care should be excluded from the composite cost and length of stay for the Ordinary Admission treatment and procedure (APC HRG). A separate cost per bed day should then be produced. This approach is consistent with that used in previous collections.

275 The HRG4 Reference Cost Grouper will only output **one HRG per** critical care period , but there may be more than one critical care period (and thus more than one critical care HRG) in the spell. Each HRG signifies the total number of organs supported in that critical care period.

276 The reported cost per occupied bed day must fully reflect the costs incurred on average for a bed occupied by a patient on any given day, for example linen costs, staff etc. See table 6 below.

277 Critical Care costs should include all costs associated with this part of the patient's spell in hospital.

The following cost pools (areas) would be expected to be included **in arriving at the cost per critical care HRG**:

- Hotel services
- Nursing and other clinical staff
- Therapy services and staff
- Medical staff (both doctors in training and consultant staff)
- Ward consumables
- Blood and blood products (however, any high cost blood products which would be included in the High Cost Drugs HRGs should be reported separately as an unbundled HRG)
- Drugs (however, any high cost drug products which would be included in the High Cost Drugs HRGs should be reported separately as an unbundled HRG)
- Diagnostics e.g. Pathology, Plain Film X Rays
- Medical and Surgical Equipment (include the costs of specialist equipment, e.g. CPAP and NIPPY machines and ensure that the costs of PbR Device Exclusions are reported in **Statement Z**)
- Theatre costs should not be included as part of the critical care episode [see below] as these will form part of the admitted patient care (Elective, Non Elective and Day Case) core HRG.

Theatre Costs

278 As a general principle, it would be expected that a patient's theatre costs would **not** be included within their critical care costs.

279 If a patient's treatment function code changes on admission to a critical care unit, a new FCE may begin, so theatre costs would not form part of total expenditure for critical care services.

280 If a new FCE does not start on admission to critical care, theatre costs should still be excluded from Critical Care, instead reported within the FCE of the original treatment function.

An example of how to cost a Critical Care Unit, taking into account theatre costs is shown below:

- Deduct critical care bed days at patient FCE level. For some FCEs, this may result in nil LOS activity. This could be because some patients are admitted to critical care then discharged quickly to local hospitals;

- If nil LOS activity then round back up to 1 bed day (refer to HRG4 Grouper Report);

- Although the result may be a relatively small cost, theatre costs remain within the relevant treatment function code HRG (as they are linked to the patient FCE) and critical care costs exclude theatre costs.

Critical Care Periods

281 For Adult Critical Care, please record the number of Critical Care Periods that have occurred within each hospital spell for reference cost purposes. Please note a critical 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 (reference DSCN 13/2005 for further details). A new critical care period commences with each new CCMDS record.

282 Discrepancies can arise when counting occupied bed days for all types of Critical Care Services Activity. For reference costs purposes, counting of critical care services occupied bed days should follow the NHS Connecting for Health Data Dictionary definition.

An example of the bed day count is shown in Table 6 below:

Table 6: Bed Day Count

Bed Day Type	Admission Date & Time	Discharge Date & Time	Count
Adult with different dates of admission and discharge	5th November 2010 13:00	7th November 2010 10.30	5th + 6th + 7th = 3 OBD
Adult with same date of admission as discharge	5th November 2010 13:00	5th November 2010 22:00	5th = 1 OBD

Given the counting convention above, where a bed is vacated and subsequently occupied by a second patient over the course of single day (24 hours), then this should be classed as 2 occupied bed days.

Data Collection

283 As with last year's collection, the 2010-11 collection has amended the service types for which data should be reported. The relevant cost data on an occupied bed day basis, for the following Adult Critical Care service types are to be reported:

- Critical Care Units (as defined by Critical Care Unit Function Type in the CCMDS, excluding the two types below)
- Burns Critical Care Units
- Spinal Injuries Critical Care Units

Within the above service types, organisations are required to report across the following categories:

- 6 Organs Supported
- 5 Organs Supported
- 4 Organs Supported
- 3 Organs Supported
- 2 Organs Supported
- 1 Organ Supported
- 0 Organs Supported

Table 7: Adult Critical Care Collection

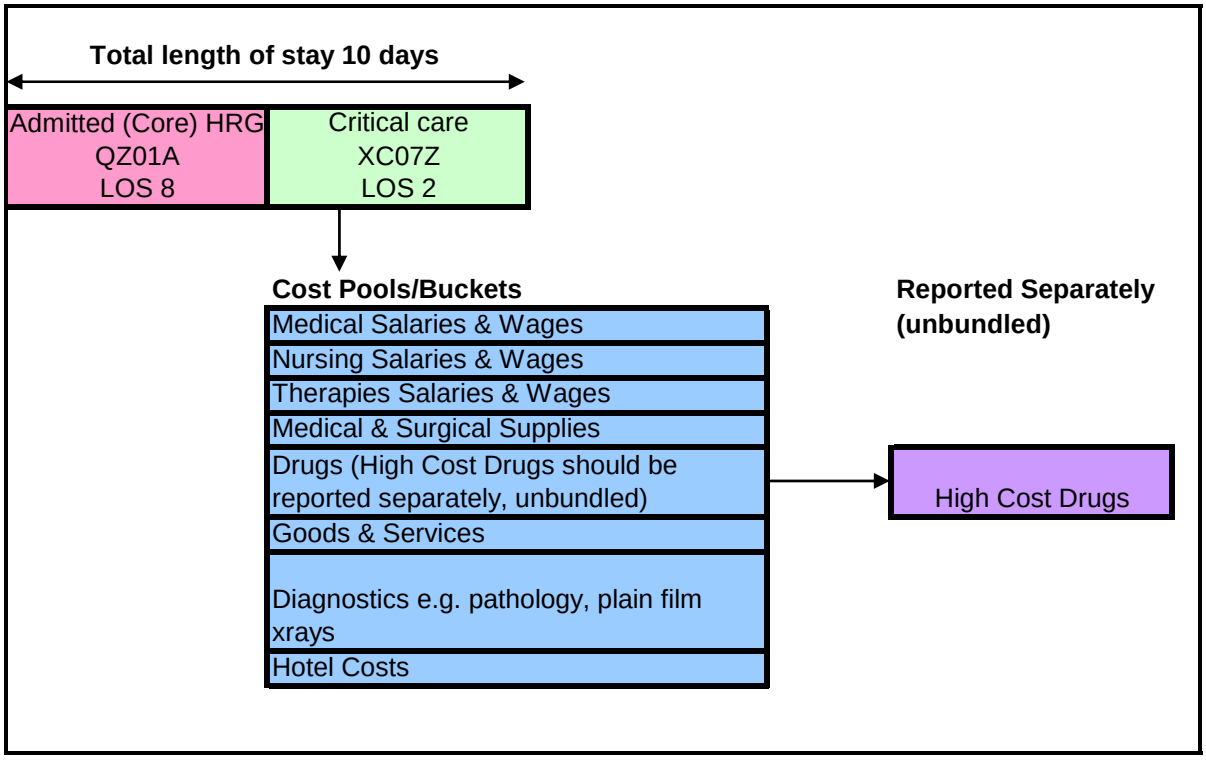
Adult Critical Care Unit	Unit Cost per Bed Day £	Total No. of Occupied Bed Days (calculated per paragraph 282 illustration)	No. of Critical Care Periods
CCU: 6 Organs Supported			
CCU: 5 Organs Supported			
CCU: 4 Organs Supported			
CCU: 3 Organs Supported			
CCU: 2 Organs Supported			
CCU: 1 Organ Supported			
CCU: 0 Organs Supported			

284 Where children are treated in adult critical care units, the cost and activity data should be reported as part of the adult critical care unit. It is not necessary for organisations to separately identify activity relating to children undertaken in an adult unit.

Costing of Critical Care

285 The following diagram shows how the critical care element of a stay is split from the admitted (core HRG) and examples of the composite cost pools/buckets. Examples of elements to be reported separately (unbundled) are also shown Please refer to the Reference Cost Guidance, chapter 5.

Critical Care



Outreach Services

286 Many organisations have critical care outreach teams that operate outside the parameters of the discrete adult critical care unit. Outreach services 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.

287 As referred to in previous years' Reference Cost Guidance documents, the full costs of such teams should no longer be included as an on-cost on the appropriate critical care unit, but instead, **the full cost of outreach teams should be reported separately in the 2010/11 Reference Costs**. As there is no data set for collecting activity for outreach services, no activity information is required – so for Unify2 reporting purposes, you should enter a "1" for this reporting line:

Outreach Services	Total Cost £ (e.g 750000)	Activity = 1

Paediatric Critical Care

288 Reference costs for Paediatric Critical Care Services are collected at HRG4 level. Costs should be collected against the HRGs according to the definitions in the Paediatric Critical Care Minimum Dataset (PCCMDS). These HRGs are non-setting specific, and as such, 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 in the admitted patient care HRG-based reference costs.

XB01Z	Paediatric Critical Care Intensive Care - ECMO/ECLS
XB02Z	Paediatric Critical Care Intensive Care Advanced Enhanced
XB03Z	Paediatric Critical Care Intensive Care Advanced
XB04Z	Paediatric Critical Care Intensive Care Basic Enhanced
XB05Z	Paediatric Critical Care Intensive Care Basic
XB06Z	Paediatric Critical Care High Dependency Advanced
XB07Z	Paediatric Critical Care High Dependency
XB08Z	Paediatric Critical Care Transportation

289 Cost and activity data to be reported on an occupied bed day basis, and each occupied bed day produces an HRG (ie one HRG per day). Please note – as HRGs XB08Z and XA06Z (below) replace 'Retrieval Services', these HRGs will be reported using 'unit cost per admission' and 'number of admissions' as the activity measure.

290 There is no requirement to identify data by organs supported for these units.

Neonatal Intensive Care

291 Reference costs for Neonatal Critical Care Services are collected at HRG4 level:

XA01Z	Neonatal Critical Care Intensive Care
XA02Z	Neonatal Critical Care High Dependency
XA03Z	Neonatal Critical Care Special Care without external carer
XA04Z	Neonatal Critical Care Special Care with external carer
XA05Z	Neonatal Critical Care Normal Care
XA06Z	Neonatal Critical Care Transportation

292 Report cost and activity data on an occupied bed day basis, each occupied bed day produces an HRG (ie one HRG per day).

293 There is no requirement to identify data by organs supported for these units.

294 Definitions of both Neonatal and Paedeatric HRGs can be found in the chapter summaries for HRG4 sub-chapters XA and XB which are available from the Casemix Service website:

http://www.ic.nhs.uk/services/the-casemix-service

Coronary Care Units

295 Coronary Care Unit data is no longer collected alongside the adult critical care data as it does not need to be reported by number of organs supported, however, will remain as Critical Care activity within the new collection system, and reported on the CFH bed day basis (as outlined in Table 8). No' levels of care' are required for this category. An example of the collection line for Coronary Care Units is shown below. The number of Critical Care Periods is also not required for these units.

The data collection requirement for Coronary Care Units in 2010-11 is as per Table 8

Table 8: Reporting of Coronary Care

Coronary Care Unit	Unit Cost / OBD £	Total No. of Bed Days (calculated per Table 8 illustration)

296 Although these costs are included within the tariffs for cardiology HRGs, it is appropriate to cost this separately for relative efficiency purposes and to further understand the composite make-up of the overall cardiology tariff.

Cystic Fibrosis Ordinary Admissions (Elective or Non-Elective)

297 This section should be read in conjunction with Section 3 – Outpatients.

298 Cystic Fibrosis categories should be used where a patient is receiving treatment for their cystic fibrosis condition, not where a patient with cystic fibrosis is receiving medical treatment for other, unrelated conditions.

299 The PbR development branch have been working with the Cystic Fibrosis Trust and a number of Cystic Fibrosis provider organisations to cost a year of care for Cystic Fibrosis patients based on their severity bandings, this work is on-going and at this time NHS organisations should continue to record and cost their activity in line with the guidance above and that detailed in the Reference Cost Guidance.

300 Costs for the different categories of patients need to be split between adults (19+) and children (up to and including 18).

301 In developing the definitions, five bands of patients have been differentiated. These are shown below.

- Band 1
  Patients, who come only to outpatients, receive outpatient care in terms of input from physiotherapist, doctors, social workers, dieticians, etc. [**Please** note, Band 1 may include IP/DC in exceptional circumstances – not for antibiotics]

- Band 2
  Patients who receive the above and in addition receive outpatient intravenous antibiotics 3-4 times a year. They may be occasionally admitted. The input as an outpatient may be more intense.

- Band 3
  Similar to 1 and 2 but essentially intravenous antibiotics are received as an Ordinary Admission (Elective or Non-Elective) 3-4 times a year. They may also have diabetes, require feeding gastrostomies, and clearly have a higher input.

- Band 4
  These patients have severe disease, come into hospital 3-4 times a year for intravenous antibiotics, and have increasing disease severity. They may have diabetes and more resistant organisms. They may be under consideration for transplantation.

- Band 5
  These patients have usually been in Band 4 for at least a year and need to stay in hospital for 4-6 months awaiting transplantation or palliative care. They are unable to go home because of oxygen dependence, nocturnal ventilation and feeding gastrostomies and need intravenous antibiotics every day, sometimes for 2-3 years. Patient's life expectancy is usually no more than a year to 18 months

.

302 Bands 1 and 2 relate primarily to care delivered through outpatient settings. As with other outpatient services, they are counted and costed on a per attendance basis. Feedback from the NHS has indicated that although rare, some Band 3 and 4 patients may also attend for outpatient appointments. These patients are identified as Cystic Fibrosis – All Other Bands within outpatients.

303 Band 2, 3 and 4 patients may have Ordinary Admission (Elective or Non-Elective) episodes throughout the year and therefore these episodes need to be counted and costed as finished consultant episodes in each band.

304 Band 5 patients can spend an exceptionally long period of time in hospital and finished consultant episodes (as for spinal injuries) are not a true reflection of overall activity and resource intensity in a given year. For Band 5 Ordinary Admission (Elective or Non-Elective) care, therefore, the services should be reported and costed on an occupied bed day basis. The number of Band 5 patients that are treated as an Ordinary Admission (Elective or Non-Elective) during a given year is shown as a Memorandum item on the collection file.

305 *As with the costing of other NHS Services, the start point has to be a control total which is the full cost of cystic fibrosis services. This control total should fully comply with the NHS costing principles, primarily relating to full absorption costing and the matching principle.*

306 *This control total is vital for the accurate costing of these services. Although the classifications can be split between outpatient and inpatient settings, the categories are not mutually exclusive.*

Hospital at Home / Early Release Schemes
(to be reported within 'Specialist Services')

307 As per previous years, the data should be reported using the following 3 'Hospital at Home' categories:

- Hospital at Home – COPD
- Hospital at Home – Fractured Neck of Femur
- Hospital at Home – Other

308 Unit costs for these services should be calculated and reported on a cost per team contact in the financial year.

309 These schemes allow the early discharge of patients from hospital in order for them to continue their healthcare in other settings, i.e. primarily in their homes.

310 Under these schemes, a patient continues to receive ongoing care from a number of health care professionals, which they may alternatively receive in a hospital setting. The range of services provided by these teams will vary on a patient by patient basis, although the care usually includes nursing and a range of therapy services.

311 These services may be provided by teams operating from both hospital and community bases. For reference costs purposes, the location of the team has no relevance.

312 Services delivered are provided on a team basis and therefore for activity and costing purposes, it is the number of team contacts in a financial year that form the activity baseline. For example, if one patient is seen by a nurse for five days, twice by a physiotherapist, and once by an occupational therapist, this is 8 team contacts in the financial year. Note that this example assumes that team members do not see patients on anything other than a team basis, i.e. that total clinical caseload for that professional relates solely to team activity.

313 Where this is not the case, and members of a clinical team also see patients in another capacity, e.g. as a Community Occupational Therapist, this activity, and associated costs, should not be reported as part of the hospital at home / early release scheme team activity, but rather, should be reported using the relevant classification within the appropriate community-based collection, e.g. community-based occupational therapy, etc.

314 Although there has been no further development of HRG4 in this area, the requirement to report data is the same as the collection in previous years. In addition to the reporting 'Team Contacts' there is also a requirement to report the number of complete **'packages of care'** (i.e. one complete package might

contain 5 contacts). This additional information enables the PbR Team to calculate an average packaging price.

315 Due to the anticipated volume of data involved, and the paucity of automated recording systems for the majority of community-based health services, it is acceptable that organisations use appropriate and reflective sample data to ascertain annual activity for Hospital at Home / Early Release Scheme Teams. There is no minimum sample time stipulated within Reference Costs; rather, the sample should be reflective of annual activity undertaken within a service area. Where this is not feasible, organisations may use informed clinical estimates if necessary, although it is advisable to retain hard copy evidence of the data source.

316 These schemes are different from Intermediate Care and Step Down Beds. Within Hospital at Home / Early Release Schemes, there is a projected end date for the care plan, following a patient's early release from an acute admission. Intermediate Care and Step Down Beds usually have a longer care path and can be delivered in hospital and community beds; these services remain excluded.

Home Delivery of Drugs (including Oxygen) and Blood Products

317 Some organisations incur costs in delivering drugs (including Oxygen) or blood products directly to patient's homes, without any associated outpatient / community activity.

318 **In order to ensure consistency in the calculation and reporting of cost and activity data in 2010-11, where drugs are delivered directly to a patient's home and no clinical activity takes place, the following costs should be excluded for reference costs purposes:**

- **Costs of drugs**
- **Costs of delivery of drugs**
- **Costs of nurse support of a non-clinical nature**
- **Administrative cost of enrolling patients and the managing of the home care service**
- **Administrative cost of contracting, ordering, invoice matching and payment**
- **Any other associated costs**

319 **This information will continue to form part of the itemised services excluded statement in 2010-11, rather than being included in the collection proper.**

Please note: For reference costs 2010-11, where possible, the administrative costs associated with contracting, ordering, invoice matching and payment for home delivery systems should be separately identified and recorded separately on statement Z.

SECTION 6

COMMUNITY SERVICES (PREDOMINANTLY SERVICES DELIVERED AT HOME/SCHOOL)

Community Services in this section refer to:

Area	**Currency for reporting**	**Paras**	**Unify2 Reporting Worksheet**
Specialist Nursing	Community Contacts, Band, Adult/Child, Face-to-Face/Non	331-335	Community and Outreach Nursing
District Nursing	Community Contacts, Band, Adult/Child, Face-to-Face/Non **or** No. of Contacts in Financial Year, Adult/Child, Face-to-Face/Non	336-339	Community Nursing Services
Nursing Services for Children	No. of Contacts in Financial Year, Face-to-Face/Non	340-343	As above
School Based Nursing Services	Total Contacts, Group and one-to-one services	344-351	As above
Health Visiting Services - 'Core' and 'Other' - Vaccinations	Community Contacts, Face-to-Face/Non, Group and one-to-one services No. of vaccinations given	352-362	As above Community Vaccinations
Community Medical Services - Paediatricians	By service, Face-to-Face/Non	363-368	Community Attendances
Community Rehab Teams	No. Team Contacts in Financial Year	370-375	Community Rehab Teams
Community Services - Podiatry - Dentistry	Attendance Attendance	376-385	Community Attendances

320 Community Providers should also refer to Table 1 of this Guidance when considering which sections of this Guidance are relevant to their organisation's Reference Cost return. For example, see section 3 for clarification on the definition of outpatients as this section (section 6) covers Community services and not Outpatient services.

321 When reporting information within this section, it is acceptable for organisations to use sample data to ascertain annual activity for all services identified within this section of the guidance, providing they are appropriate and reflective samples. This is in response to the anticipated volume of data involved, and the paucity of automated recording systems for the majority of community-based and outreach specialist and non-specialist nursing and community medical services.

322 There is no minimum sample time stipulated within Reference Costs; rather, the sample should be reflective of annual activity undertaken within a service area. Where this is not feasible, organisations may use informed clinical estimates if necessary, although it is advisable to retain hard copy evidence of the data source.

323 *Costing community services at staff group level has been the subject of debate and pilots over several years. One of the major stumbling blocks to move to a consistent activity baseline has been the lack of a standard minimum data set and detailed service descriptions for the majority of services commonly classified as "community services".*

324 *Costing pilots undertaken in previous years, alongside feedback from NHS organisations, have considered the costing of a range of community services. Given the high level of participation and the consistency of the findings and comments, it was felt that this constituted a sound base from which to produce interim reference costs and benchmarks for a range of community services.*

325 *Reference costs in the acute sector have been linked with Healthcare Resource Groups (HRGs). Due to the problems of data sets and definitions outlined above, these are not fully available for community services. This should not prevent improvements in the costing of these services from progressing however, nor for interim measures to be included as part of the National Schedule of Reference Costs for these services.*

326 *The costing guidance and definitions that follow, form the basis of costing community services including the mandatory collection for the National Schedule of Reference Costs. As with all reference cost information, the analysis is based on retrospective data. The range of community services will continue to be refined until all services are included. In addition, the basis of these services remains iterative as data quality improves.*

327 *This guidance also applies for 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 a continuity of care to patients.*

Scope of Community Services

328 *Whilst the general trend is to standardise activity measures wherever possible, these must be representative and reflective of the services being provided. These services are very divergent and therefore, while achieving some standardisation, some differences have resulted.*

329 *As these services are increasingly delivered in a range of settings, input from other health professionals, including practice nurses will occur. As reference costs relate to the full costs of the provision of these services, the costs of staff, travel, dressings etc, need to be included to meet the NHS costing principles. All relevant costs have to be included to ensure comparability and the key issue is the cost of services and not the funding stream. Services that are categorised as GMS and PMS are excluded however.*

330 *Given the differences, each group of services are considered in turn.*

Specialist Nursing Services:

331 Specialist Nursing Services are reported using 'Community Contacts' as the activity currency, disaggregated at Band Level (see below), split further by Adult/Child and Face-to-Face and Non-Face-to-Face.

332 The list of specialist nursing service categories remains largely unchanged from the previous collections. The full list is therefore: -

- Band 1 – Cancer Related
- Band 2 – Palliative / Respite Care
- Band 3A - Arthritis Nursing / Liaison
- Band 3B - Diabetic Nursing / Liaison
- Band 3C - Cardiac Nursing / Liaison
- Band 3D - Asthma / Respiratory Nursing / Liaison
- Band 3E - Breast Care Nursing / Liaison
- Band 3F - Parkinson / Alzheimer Nursing Liaison
- Band 4 – Continence Services
- Band 5 - Stoma Care
- Band 6 – Intensive Care Nursing
- Band 7 – Infectious Diseases
- Band 7B – Tuberculosis (TB) Specialist Nursing
- Band 8 – HIV / AIDS Nursing Services
- Band 10 - Haemophilia
- Band 11 - Transplantation Patients (this includes patients on pre and post transplantation programmes)
- Band 12 - Enteral feeding.
- Band 13 – Tissue Viability Nursing / Liaison
- Band 14 – 'Treatment Room' Nursing Services (to be used for nursing staff based in GP surgeries).
- Band 15 – Active Case Management
- Band 16 – Community Cystic Fibrosis
- Band 17 – Other Specialist Nursing [e.g. sickle cell]

333 Please not that for Band 3C – 'Cardiac Nursing / Liaison', the **PbR Team in conjunction with Community Leads are continuing to review this area for Community Providers for the 2010-11 collection** and this band will subsequently be disaggregated further.

334 Please not that for Band 4 – 'Continence Services' includes all recipients of these services i.e. those in regular receipt of supplies as well as those being attended by these nurses. All patients in receipt of supplies rather than being attended by a specialist nurse should be reported as non-face to face activity. This approach also applies to Band 5 Stoma Care**.**

335 **As with collection in previous years**, Band 15 – 'Active Case Management' and Band 16 – 'Community Cystic Fibrosis' continue to be collected in 2010-11, services to be costed under this 'band' are to include 'Community Matrons'.

District Nursing Services

336 With the increase in 'bands' associated with Specialist Nursing, Reference Cost Leads should make every effort to **map all District Nursing** work to the 'bands' shown above and report this data within this area of the collection workbook. Only if this is not possible should you continue to report under the District Nursing Categories.

337 Therefore, District Nursing Services should be reported using 'Community Contacts' as the activity currency, disaggregated at Band Level (see below), split further by Face-to-Face and Non-Face-to-Face as per Specialist Nursing.

338 Only if data cannot be mapped to the Bands above, should data for District Nursing Services remain sub-divided across the two sub-sets of : -

- District Nursing Services : Adult : Face to Face No. of Contacts in Financial Year
- District Nursing Services : Adult : Non-Face to Face No. of Contacts in Financial Year

339 **As per previous years**, the 'Child' category is covered by the 'Nursing Services for Children' section of this guidance.

Nursing Services for Children

340 There is no change to the guidance from the previous reference costs collections, but NHS organisations should note that PbR development work is ongoing to include new definitions in future years to align with the 'Community Medical' section of this guidance.

341 In addition to the specialist nursing services above, the NHS provides a range of other nursing services for children. Although a number of separate elements are identified as composing Nursing Services for Children, total community contacts in the financial year and unit costs will be reported for all these services as one composite group.

342 Nursing Services for Children exclude the specialist nursing services detailed in paragraph 332 above but does include the following elements: -

- Vulnerable Children Support (including Child Protection and Family Therapy);
- Development Services for Children (including Psychology);
- Paediatric Liaison; &
- Other Child Nursing Services - those not included in Specialist Nursing and School Based Child Health services (including 'Looked after children nurses').

343 With regard to child protection services, **where separate to that performed by community paediatricians** (see paragraph 363) the following should be noted:-

- In general, the cost of child protection is an on-cost of 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.

- Where funding is received from non-NHS sources to help with the costs of funding this post / service, it is valid to net off such income from the expenditure incurred, in line with the Matching Principle.

- Where there is a discrete child protection service that does not have contact with children, but rather is an advisory service to other elements of health care, these costs should be apportioned between the service areas that receive its advice.

- Where the child protection service offers advice to non-NHS bodies, e.g. social services / the police, etc., these elements of cost can rightly be excluded.

- For consistency with other reference cost definitions, the activity relating to meetings about the patient are not counted for reference cost purposes. The costs of these meetings should be included as an overhead and apportioned out as appropriate.

- The above treatment is applicable to all child protection teams, including those that consist of a team of consultants and nurses.

School Based Children's Health Services

344 A number of health services and health checks are performed through educational facilities. School based services, while having a significant levels of nursing input, also have input from community paediatricians.

345 Unlike Nursing Services for Children, school based services are sub-divided for reference costs purposes, disaggregated at a 'group' and 'one-to-one' services level and reported using currency total community contacts in the financial year and unit costs as below:

- Core Services (**introduced for 2008/09 collection**)
- Other services (includes routine medical checks, sexual and reproductive health advice, family planning, smoking cessation, substance misuse advice & support, etc.)

346 The table below gives Providers a steer on the activities to include within the reporting headings 'Core' and 'Other' to ensure consistency in reporting. The list below is not exhaustive, not all Providers may be undertaking all the activities on the list at this stage and/or activities may be known by a slightly different name. Therefore, please use the table below as a guide for **the purpose of Reference Cost returns only**

Core	**Other School Based Children's Health Services**
School Entry Review	Routine medical checks (school drop ins)
Yr 6 obesity monitoring	Sexual health advice
	Family planning
	Smoking cessation
	Substance misuse advice and support
	Obesity (targeted health promotion)
	Behaviour management (sleep, diet, healthy lifestyles, relationships etc)
	…
	Any other services

Please note:
*1. These definitions are given for the **purpose of reference cost returns only**.*
2. Consistent with the reference cost guidance, Vaccinations and Immunisations are to be separately identified, so are not included on the list above.

347 In addition, there is a requirement to report activity for School Based Vaccinations using the currency 'Number of Vaccinations' given and 'Unit Cost' per child:

- Vaccination Programmes (includes Vaccination Programmes such as MMR, Tuberculosis and Meningitis).

348 The unit cost will include all costs (including administration, nursing and medical costs), and not just the cost of vaccines where these are part of the service costs.

349 Vaccination programmes that are jointly funded by non-NHS providers (including GPs) should not be reported in Reference Costs 2010-11; as such, unit costs are not calculated on a total absorption costing basis and thus may distort national averages. Similarly, where a GP provides the vaccination, but it is administered by a School Based Nurse, the costs incurred by the NHS provider for this element

of service (including administration, nursing and medical costs, and appropriate on-costs) should be **excluded** from Reference Costs, as should all associated activity.

350 In costing all school based services, it is required that the full cost of delivering these services, not just associated nursing costs, should be included. School-based Children's Health Services include all services provided in the school setting, and not just those nurses that are school-based and providing health services.

351 Organisations should be aware that **as for previous years**, activity that is collected for all School Based Health Services should be split into Multi and Uni-Professional.

Health Visiting Services

352 In 2010-11, the levels of 'Core' Visiting Services and 'Other' Visiting services are reported split between face-to-face and non-face-to-face total community contacts in the financial year, with face to face community contacts sub-divided into 'one-to-one services' and 'group services'.

- Core Visiting Services (**introduced for 2008/09 collection**)
- Other Health Visiting Services (excluding Post-Natal)
- Post-Natal Visits (see below)

353 The table below gives Providers a steer on the activities to include within the reporting headings 'Core' and 'Other' to ensure consistency in reporting. The list below is not exhaustive, not all Providers may be undertaking all the activities on the list at this stage and/or activities may be known by a slightly different name. Therefore, please use the table below as a guide for **the purpose of Reference Cost returns only.**

Core	Other Health Visiting Services
Between 6-8 weeks contact	Clinics
1 year contact	Telephone Triage
2-3 year contact	Safeguarding
	Looked after Children
	Child in Need
	Parenting of Child
	Parental Health
	Prison Service
	Antenatal contact
	Any other services

Please note:
*1. These definitions are given for the **purpose of reference cost returns only**.*
*2. Vaccinations, Immunisations, and **Post-Natal visits are to be separately identified**, so are not included on the list above (see reference cost guidance for further details) i.e. only include the other (non-vaccination) elements of the Healthy Child Strategy as a core service.*

354 Please note that Post-Natal visits are not required to be split as per 'Core' and 'Other', instead please report using the currency 'Number of Visits' and 'Unit Cost' per visit.

355 In addition, there is a requirement to report activity for Health Visiting 'Vaccinations' using the currency 'Number of Vaccinations' given and 'Unit Cost' per child:

- Vaccinations and Immunisations (number of vaccinations given)

Post-Natal

356 Post-natal visits are separately identified for community midwives, and post-natal visits carried out by health visitors are reported for consistency. As with vaccinations, the full cost of this element of service needs to be identified in order to accurately calculate the unit cost per visit.

357 When counting activity for Post Natal Visits, the following should be noted: -

- Post-natal visits are those visits undertaken up to 28 days after the birth.
- The collection currency for post natal visits for health visitors is the visit itself. From a Reference Cost perspective, therefore it does not matter whether the health visitor sees the mother, baby or both, as the activity counted is the visit itself.

- Visits should only be counted where the patient was seen (mother,baby or both see above). Costing and counting treatment should follow the principle used for 'did not attends' (DNAs) in a clinic setting, where the cost of these are an oncost on the service itself, and the activity is not counted.

358 All other services, including costs associated with the public health role of Health Visitors, are to be costed and reported on a total community contacts in the financial year basis. This would therefore include any post natal visits that occur after 28 days later than the birth.

Vaccinations

359 Vaccinations and Immunisations are to be separately identified for consistency with school based programmes and GP based services. This will allow an overview of these services across all sectors. The costs of these services are fully inclusive of all costs, e.g. clinic costs, staff costs, travel costs (for home visits), etc. as well as the cost of the vaccine.

360 For reporting purposes, activity will be based on the number of individual vaccinations given in a year. For example, if 2 vaccinations from a course of 3 are given in the year, this will count as 2. This will allow for uncompleted courses as it is the individual number of vaccinations and immunisations that are the activity unit. For the purposes of Reference Costs, vaccinations may be equated with number of injections given.

361 In costing these services, full absorption costing should be used, with any income / fees from patients matched to the expenditure, thus reporting the quantum charged to contractual arrangements.

362 Only vaccination programmes that are jointly funded by non-NHS providers (including GPs) should not be reported in Reference Costs 2010-11; as such, unit costs are not calculated on a total absorption costing basis and thus may distort national averages. Similarly, where a GP provides the vaccination, but it is administered by a Health Visitor, the costs incurred by the NHS provider for this element of service (including administration, nursing and medical costs, and appropriate oncosts) should be **excluded** from Reference Costs, as should all associated activity.

Community Medical Services

Community Paediatricians

363 As documented in section 3 (Outpatients) of this guidance, where neurodisability work conducted by community paediatricians is recorded, this should be recorded under TFC 291 (Paediatric Neuro-Disability) and not in the Community Paediatrics TFC 290. The treatment function code is the important factor, not the type of specialist delivering the treatment. Community paediatrics (CP60) should then include all other components of the service (see below).

364 All other activity carried out by **community paediatrics** should **be recorded in the community section of the reference cost return in code 'CP60'** with the currency of collection as 'Number of contacts'.

365 To tie in with the National Service Frameworks and the nature of the work performed, an expansion in the scope for 'community paediatricians' was introduced in the 2007/08 reference cost collection. Providers should make a best attempt to capture 'community paediatricians services' (face-to-face and non-face-to-face) as follows:

- safeguarding;
- other statutory work for social services;
- statutory work for education
- child public health; and
- other (used as a default should you not be able to split the costs/activity in this manner)

366 As a guide of what to include within each section above please see the guidelines below:

- Safeguarding (FS): Include here all child protection medical examinations for suspected physical/sexual/emotional abuse/neglect, attendance at child protection conferences where child/parent present;

- Safeguarding (NS): include here all telephone contacts with child/parents on safeguarding. Contacts about patients (with the exception of Oncology Multi-disciplinary Teams meeting about a patient) cannot be counted as valid activity;

- Statutory work for social services (FSS): include here all adoption medicals, initial and review LAC medicals, medicals specifically conducted for children in need;

- Statutory work for social services (NSS): include here all telephone contacts with child/parents Contacts about patients (with the exception of Oncology Multi-disciplinary Teams meeting about a patient) cannot be counted as valid activity. The role of adoption adviser, panel preparation and attendance and designated LAC doctor should be included as 'on costs' for the service;

- Statutory work for education (FSE): include here all medical assessments as part of statutory assessment, where the child/young person has been seen specifically to provide the report. Do not include here reports written from the notes for child/young person already known to the service i.e. where the child is not seen to prepare the report. Also include here annual reviews or MDT meetings on children with identified SEN where child/parent is present;

- Statutory work for education (NSE): include here all telephone contacts with child/parents. Contacts about patients (with the exception of Oncology Multi-disciplinary Teams meeting about a patient) cannot be counted as valid activity. The role of Designated Medical Officer for SEN, panel preparation and attendance should be included as 'on costs' for the service;

- Child public health (FCPH): include here medical assessments done as part of the child health promotion programmes and vaccinations given by community paediatricians, where these are not provided by GPs. Also include any face-to-face consultations with **parents** for immunisation advice, where these can be identified e.g. immunisation advice clinics;

- Child public health (NFTF): include all telephone contacts with child/parents regarding immunisations. The role of Immunisation Coordinator and Child Health Promotion Coordinator, including telephone advice line for **professionals**, should be included as 'on costs' for the service - contacts with others about patients are not included.

- Other (FO): include here any other face-to-face clinical activity not included above or under 291 for neurodisability;

- Other (NO): include here all telephone contacts with child/parents. Contacts with others about patients cannot be included.

367 Please note, Treatment Function Code 290 is also named 'Community Paediatrics' and may be used in Trusts to identify work collected under CP60 on Trust computer systems. For reference cost reporting purposes, where appropriate all activity (and costs) clinically recorded under TFC 290 should be reported under code 'CP60'. This ensures that all data are reported consistently in one place.

368 Although most of this work may be driven by social services and education, it is the NHS who pay for it. Please note that only NHS funded activity should be included in the reference cost return. Therefore, if any of the activity above **is** funded by a local authority, or as part of a pooled budget arrangement, then please treat as per Section 16 of this guidance.

Other Community Medical Services

369 All other community medical services not captured within this section (or section 7) i.e. non-vaccination / immunisation / paediatric services should be reported in aggregate form using 'Total community contacts in the financial year' as the collection currency.

Community Rehabilitation Teams

370 There is work in progress within PbR to further develop/improve this section for future collections. However there is no change for the 2010-11 collection.

371 Services delivered are provided on a team basis and therefore for activity and costing purposes, it is the 'number of team contacts in a financial year' that form the activity baseline. For example, if one patient is seen by a nurse for three days, twice by a physiotherapist, and twice by a speech and language therapist, this is **7** team contacts in the financial year.

372 Community Rehabilitation Teams are usually comprised of a number of health care professionals providing ongoing care to patients in a community setting. The range of services provided by these teams will vary on a patient by patient basis, although the care usually includes nursing and a range of therapy services. These services may be provided by teams operating from both hospital and community bases. For reference costs purposes, the location of the team has no relevance, although care should be taken not to double count any activity reported using the HRG4 Rehabilitation categories.

373 Note that this example assumes that team members do not see patients on anything other than a team basis, i.e. that total clinical caseload for that professional relates solely to team activity.

374 Where this is not the case i.e. members of a clinical team also see patients in another capacity, e.g. as a Speech and Language Therapist, activity, and associated costs, should not be reported as part of the community rehabilitation team activity. They should instead be reported using the relevant classification within the appropriate community-based collection, e.g. community-based speech and language therapy, etc.

375 Some community rehabilitation teams provide rehabilitation services for patients with specific diagnoses or conditions, for example, neurological community rehabilitation teams. At present, there is no requirement to separately identify the types of rehabilitation services that these teams provide. Cost and activity data for services provided by all community rehabilitation teams should be reported using the single composite category, as in previous years.

Podiatry Services

376 These services can be delivered in a number of settings, such as the patient's home, GP surgery, etc. All activity and costs for each service provided in a community setting need to be recorded, regardless of setting, using 'Attendance' as the base activity measure. Where this type of activity is provided as part of an admitted patient care (Elective, Non Elective and Day Case) or outpatient attendance, the costs should be reported within the composite cost of the admitted patient care HRG / outpatient attendance.

377 These services should be domiciliary and/or nursing home - where the outpatient attendance is solely for podiatry services, costs and activity should be reported **using specialty code 653** within the outpatient return [Section 3 refers].

378 Some patients directly access these services (as with a range of other services). As in previous years, **there is a requirement to separately identify cost and activity data for podiatry services.**

379 For the purposes of Reference Costs:

- Podiatry is defined as the "assessment, diagnosis and treatment of conditions of the foot, with the aim of eradicating or controlling foot pathologies, where possible, with a scope of practice which includes general podiatry, biomechanics, surgery, high risk care and foot health education techniques".

Community Dentistry

380 Community Dentistry should be reported at an aggregate at an 'Attendance' basis.

381 As with physiotherapy, occupational therapy, and speech & language therapy, if Dentistry is included as part of an Ordinary Admission (Elective or Non-Elective) or day case stay, the costs should be reported within the appropriate Ordinary Admission (Elective or Non-Elective) or day case HRG unit costs. Similarly, where the treatment is included as part of an outpatient attendance, the costs will form part of the composite costs of that outpatient attendance, unless a **discrete outpatient attendance**.

382 Other contacts (i.e. through direct access or from community based services) are shown separately. These are reported as contacts and are costed on an 'attendance' basis.

383 Community dental activity should include both the costs and activity of face to face dental officer activity in clinics and also the costs and activity of 'screening' contacts that such officers carry out in schools (where each child screened constitutes a contact, since each requires one-to-one activity). As in previous years, Primary Dental Services (PDS) are excluded from the 2010-11 reference costs collection.

384 Please note, that there is currently no work underway with PCT Dental Services on casemix. Primary Care Dental work are excluded from the reference costs collection (see below).

385 Some patients choose to access primary dental services provided by undergraduate dental students in secondary care settings as an alternative to GDP services in primary care. As these services are substitutes for primary care based provision they should also be **excluded** from reference costs. Consultant-led oral surgery and orthodontic treatment (including post-graduate student activity) which takes place in secondary care, should, however be **included** in reference costs.

Additional Notes

Face-to-Face and Non Face-to-Face Community Care

386 As no NHS Connecting for Health definition exists for face-to-face community contacts, where the activity currency for these services is **total face to face community contacts in a financial year**, the definition should be aligned with that of an Outpatient, described in Section 3 of the Guidance.

387 It is acknowledged (particularly for areas such as Specialist Nursing) that the move to telephone-based patient interaction is a growing trend, and to integrate this activity and cost with face-to-face data would be inappropriate, and could lead to distortion in the data reported.

388 Contacts with proxies only count if the contact is in lieu of the contact with the patient, and the proxy is able more effectively than the patient to ensure that the specified advice/treatment devised for the patient 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.

389 Therefore, as with outpatient activity, a valid non face-to-face contact should replace the need for an outpatient face-to-face attendance i.e. telephone contacts solely to inform patients of results are excluded and contacts about the patient via text message received either by the patient or by proxy do not count as valid non face to face activity.

390 As a general principle, it should be noted that the same patient can access a service as a face to face contact and as a 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 in 2010-11. Although some patients might be reported in both categories, not all would be expected to do so.

Adult/Child split

391 Where an Adult/Child split is required within this section, age is split between:

- Children (up to and including 18 years old); &
- Adult (over 18).

392 We are aware that for some Community Services, a child is recognised up to and including 16 years old, however for consistency across PbR, the split detailed above is used for costing purposes.

One-to-One / Group Services

393 Note that where group sessions are the activity required, each group contact should be counted as **one** 'group services' community contact in the financial year. This is irrespective of the size of the group involved, which may be a class, a specific year, or the whole school.

394 For the counting of group sessions, the activity count is the number of sessions. The number of therapists or attendees is irrelevant e.g. 2 therapists running a session for 20 people is reported as Activity = 1, Cost = £x.

Sample Size

395 Due to the anticipated volume of data involved, and the scarcity of automated recording systems for the majority of community-based health services, it is acceptable that organisations use appropriate and reflective sample data to ascertain annual activity for Community Rehabilitation Teams. There is no minimum sample time stipulated within Reference Costs; rather, the sample should be reflective of annual activity undertaken within a service area. Where this is not feasible, organisations may use informed clinical estimates if necessary, although it is advisable to retain hard copy evidence of the data source.

Other

396 Where evening / twilight services are offered as an extension to a community-based nursing service, this should be reported under the appropriate category, e.g. District Nursing, Specialist Nursing, etc., thus forming part of the composite costs and activity of that community-based nursing service.

397 Please note, Diabetes services should be reported as an Outpatient or within Community Specialist Nursing.

398 **Note that Sexual and Reproductive Health Clinics (previously referred to as family planning clinics) are included within reference costs as outpatients, (code FPC) and should be reported at first and follow up attendance level, regardless of the physical setting of the clinic. They can therefore be found on the outpatient collection file.** Additional information can be found in Section 3 of this document.

SECTION 7

ALLIED HEALTHCARE PROFESSIONALS

Community Services in this section refer to:

Area	Currency for reporting	Paras	Unify2 Reporting Worksheet
Podiatry	No.Attendances	399-401	Community Attendances
Dietetics	No.Attendances	402	Community Attendances
Therapy Services • Physiotherapy, • Occupational Therapy, • Speech and Language Therapy	No.Total Contacts in Financial Year	403-412	Tbc

Podiatry Services

399 These services can be delivered in a number of settings, such as the patient's home, GP surgery, etc. All activity and costs for each service provided in a community setting need to be recorded, regardless of setting, using contacts as the base activity measure. Where this type of activity is 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 HRG / outpatient attendance. Where the outpatient attendance is solely for podiatry services, and is a booked appointment, costs and activity should be reported using specialty code 997 within the outpatient return [Section 3 refers].

400 Some patients directly access these services (as with a range of other services). As in previous years, **there is a requirement to separately identify cost and activity data for podiatry services. This data should be returned against Podiatry Services in the Community Attendances worksheet, to differentiate against non-directly accessed podiatry.**

401 For the purposes of Reference Costs,

- Podiatry is defined as the "assessment, diagnosis and treatment of conditions of the foot, with the aim of eradicating or controlling foot pathologies, where possible, within a scope of practice which includes general podiatry, biomechanics, surgery, high risk care and foot health education techniques".

Dietetics

402 As with physiotherapy, occupational therapy, and speech & language therapy, if Dietetics are included as part of an Admitted Patient Care stay, the costs should be reported within the appropriate Ordinary Admission (Elective or Non-Elective) or day case HRG unit costs (as appropriate). Similarly, where the treatment is included as part of an outpatient attendance, the costs will form part of the composite costs of that outpatient attendance, unless a **discrete/directly accessed attendance**. **In the case of a discrete or directly accessed attendance for Dietetics please report under Dietetics Services on the Community attendances worksheet to keep costs and activity for this service seperate.**

Community Therapy Services

403 This section covers the following services undertaken in the community (For details of the Outpatient Therapy Services categories see Section 3):

- Physiotherapy,
- Occupational Therapy,
- Speech and Language Therapy,

404 Therapy services may be provided in the community and may be accessed directly by a patient. Such access entails the patient accessing the service through a direct referral, either from a health or other professional, including a GP, or self-referral.

405 To clarify service definitions;

- Therapy services which are accessed directly by a patient, and where that patient attends an outpatient clinic, solely for the purpose of receiving therapy treatment, should be reported as outpatient activity within the relevant therapy category and attendance type (first / follow up, Attendances/Multi-professional attendances– see section 3).
- Community Therapy services, should be reported as such, irrespective of the source of referral, using the relevant category.

406 Community Therapy services are where treatment is not delivered in a clinic setting but where the intention is to see a single patient in a specific setting. They may be delivered by community based therapy staff or on an outreach basis. The services may, but not exclusively, be follow-on treatments from earlier events, or relate to continuing care in community settings. In 2010-11, services reported as community should include direct access / referral to services provided in the community.

407 Following feedback from the NHS, the number of categories required for community therapy services was extended, to better reflect the treatment that patients receive. Thus for each service, four categories will form the basis of cost and activity analysis for reference costs. These are: -

- Adult – One-to-One Services
- Adult – Group Services
- Children – One-to-one Services
- Children – Group Services

408 As a result of feedback from the NHS, the data for each category in therapy services must be reported for the **total number of community contacts in a financial year (not first community contacts)** and a unit cost per community contact. This will ensure that reported unit cost differences can be related to the differing costs of similar clinical practice, rather than differences in the average number of contacts that a patient has within a particular course of treatment.

409 Where a therapist provides group sessions, each group community contact should be counted as **one** 'group services' community contact in the financial year. This is irrespective of the size of the group involved or the number of therapists running the session.

410 No attempt is made in the 2010-11 collection to differentiate between patient casemix, other than that associated with age. It is anticipated that in future collections, casemix will be reflected in the collection categories used for these services.

411 Due to the anticipated volume of data involved, and the paucity of automated recording systems for the majority of community therapy services, it is acceptable that organisations use appropriate and reflective sample data to ascertain annual activity for Community Therapy services. There is no minimum sample time stipulated within Reference Costs; rather, the sample should be reflective of annual activity undertaken within a service area. Where this is not feasible, organisations may use informed clinical estimates if necessary, although it is advisable to retain hard copy evidence of the data source.

412 To reiterate, in 2010-11, therapy services will be:

- Reported as community therapy services where treatment is carried out in the community, irrespective of the source of referral for that patient. (See Section 6 for further details).

In addition, to clarify from section 3 (outpatients), therapy services will be:

- Reported as part of the composite Admitted Patient Care cost where they are provided during an Admitted Patient Care stay;
- Reported as part of the composite outpatient cost where they are provided during an outpatient attendance;
- Reported as outpatient therapy services where treatment is carried out in a clinic setting, where the patient attends solely for therapy treatment, irrespective of the source of referral for that patient.

SECTION 8

SERVICES SEPARATELY IDENTIFIED (I.E. "UNBUNDLED")

Unbundled Services covered within this section refer to:

Area	Currency for reporting	Paras	Unify2 Reporting Worksheet
Chemotherapy	Cycles of Treatment and HRG4 Deliveries and HRG4	423-449 433	CHEMTHY – Procurement CHEMTHY – Delivery CHEMTHY – Same Day
High Cost Drugs	Spells and HRG4 Attendances and HRG4	450-468	HICOSTDRUGS – APC HICOSTDRUGS – OP & Other
Diagnostic Imaging ('Outpatient', 'Direct Access' and 'Other')	Examinations and HRG4	469-492	DIAGIM
Radiotherapy	Admissions and HRG4 Treatments and HRG4 Attendances and HRG4	493-508	RADTHPY – Ordinary Admission (Elective or Non-Elective) RADTHPY – Planning RADTHPY – Treatment
Rehabilitation Services	Attendances and HRG4 Occupied Bed Day and HRG4	509-541	REHAB – per Attendance REHAB – per Bed Day
Specialist Palliative Care	Bed Days and HRG4 Attendances and HRG4	542-556	SPAL – Ordinary Admission (Elective or Non-Elective) & DC SPAL – OP & Other
Renal Dialysis	Sessions and HRG4	557-581	RENAL
Patient Transport Services	Attendances	582-591	PTS
Hospital Travel Cost Scheme	Attendances	592-594	HTCS

Unbundling

413 The costs and activity of the services listed above should be separately identified (i.e. unbundled) from all Admitted Patient Care (excluding Diagnostic Imaging) and Outpatients. These services should be reported using HRG categories unless specified otherwise. Please note, however, unbundled services are **not separately identified (unbundled) from A&E activity,** and therefore should remain in the A&E composite activity and costs.

414 For most of the areas above (see individual areas), if you have activity data that does not fit into the definition of Admitted Patient Care (Elective, Non-Elective, Day Case, and Regular Day/Night) or Outpatient, and is not separately collected elsewhere in the Reference Cost collection, then report all HRGs, under the '**Other**' category e.g's Community, GP contact.

415 The cost of unbundled HRGs have been developed to recognise the fact that some patients treated for a condition will require high cost treatment, whereas another patient with the same condition may not. To improve the performance of HRGs and facilitate fairer resource allocation it was identified that services needed to be unbundled from the core HRG for the care episode.

416 For detailed information on all of the HRGs used in this section (including mapping of codes to HRG4 categories), please click on the website below and scroll to 'Code to Group Table', HRG4 Definitions, HRG4 Design Concepts etc

http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/healthcare-resource-groups-4-hrg4

Unbundling - Coding Requirements

417 Please note that it is important that clinicians and the pharmacy department clearly identify the use of unbundled services in clinical notes and ensure that this information is communicated to coding staff. The 2010-11 HRG4 Reference Cost Grouper has been developed so that an OPCS 4.5 code maps directly to a HRG. Therefore, it is crucial that organisations implement the mandated coded data at the appropriate level.

418 The completion of the latest Commissioning Data Set (CDS) is mandatory although there are some optional fields within it. Organisations wishing to accurately cost outpatient activity are advised to record the activity in the CDS, or in the absence of coding, use local workarounds. Therefore, organisations are advised to align their Patient Admin Systems (PAS) with CDS6 to ensure more data flow to produce the HRG4 data.

419 For all of the HRG4 categories in this section generated by the 2010-11 Reference Cost Grouper, you will need to have **at least 6 months of OPCS 4.5-coded activity, you may extrapolate the casemix of this data to reflect the full 12 months of data** (with reference to further information in this chapter).

420 Unfortunately, **if organisations have not mandated the required OPCS coding** (or where Outpatient coding is not implemented), there is no 'single right answer', suitable for all organisations, for obtaining the correct activity to generate the unbundled HRGs. Instead we advise three approaches which organisations could adopt to treat datasets that are incomplete, in order to produce relevant unbundled activity data:

- In line with NHS Connecting for Health coding guidance, organisations should ensure all coding is completed and input on the main PAS. The HRG4 Reference Cost Grouper will then automatically produce the activity data based on this input;

- If this is not possible, organisations should use a robust clinical information system to retrospectively amend the PAS dataset within a data warehouse (or similar), to reflect the true picture of the activity undertaken. Please note, it is important to take account of NHS Connecting for Health coding rules around the unbundled activity when manually coding the activity from the stand-alone system;

- If neither of the above methods are possible, then organisations should manually group the non-core activity using robust data from a clinical information system to generate unbundled HRGs so that this activity will not be directly unbundled from an episode on the main PAS but will be generated independently. If this method is used then any unbundled HRGs generated from the main PAS would need to be discounted. This should not have any effect on the core HRG derived from the main PAS.

421 Following feedback from the NHS (as part of the 2006/07 collection), some of the areas in this section were identified as areas where organisations found the costing and reporting of this activity, at HRG4 level, challenging. As referred to earlier (paragraph 17), the PbR Team managed this through the implementation of 'Reserve Codes' in the 2007/08 collection. Reserve Codes will no longer be available in the 2010-11 collection and **organisations should make every effort to report unbundled areas by the relevant HRGs**.

422 Activity data should be sourced as soon as possible to facilitate this process. Please also refer to the information directly above where a full 12-month's data may not be available.

Chemotherapy

423 **For the 2010/11 Reference Costs collection the activity and costs will continue to be reported using the HRG4 categories. The Chemotherapy HRG4 categories are to be used for reporting the attendance costs and chemotherapy drug costs (including any pharmacy dispensing oncosts and associated drugs to deal with the symptoms or side effects of the chemotherapy drugs themselves).**

424 **The Department is working closely with the Casemix Service from the NHS Information Centre (NHSIC), the National Cancer Action Team (NCAT), NHS Connecting For Health (CFH) and national steering groups, in order to develop a national tariff for Chemotherapy using HRG4. The 2010-11 guidance for chemotherapy is mainly unchanged from previous years.**

HRGs & Units of activity

425 In respect of Chemotherapy, "Regular Day/Night Admissions", "Day cases" and "Outpatients" are all treated the same from an HRG perspective and all allocated the same HRGs. For "Ordinary Admission (Elective or Non-Elective)" see paragraph 432.

Table 9: Chemotherapy HRGs (Procurement and Delivery)

SB01Z	Procure Chemotherapy drugs for regimens in Band 1
SB02Z	Procure Chemotherapy drugs for regimens in Band 2
SB03Z	Procure Chemotherapy drugs for regimens in Band 3
SB04Z	Procure Chemotherapy drugs for regimens in Band 4
SB05Z	Procure Chemotherapy drugs for regimens in Band 5
SB06Z	Procure Chemotherapy drugs for regimens in Band 6
SB07Z	Procure Chemotherapy drugs for regimens in Band 7
SB08Z	Procure Chemotherapy drugs for regimens in Band 8
SB09Z	Procure Chemotherapy drugs for regimens in Band 9
SB10Z	Procure Chemotherapy drugs for regimens in Band 10
SB16Z	Procure Chemotherapy drugs for regimens not on the national list

SB11Z	Deliver exclusively oral chemotherapy
SB12Z	Deliver simple parenteral chemotherapy at 1st attendance
SB13Z	Deliver more complex parenteral chemotherapy at 1st attendance
SB14Z	Deliver complex chemotherapy, including prolonged infusional treatment at 1st attendance
SB15Z	Deliver subsequent elements of a chemotherapy cycle
SB17Z	Deliver chemotherapy for regimens not on the national list

SB97Z	Same day chemotherapy admission/attendance

426 Chemotherapy delivery costs should be separated out of the composite costs of other treatments and shown separately.

427 Please note, current coding guidance stipulates when to code delivery of oral chemotherapy (HRG4 code SB11Z) If a regimen includes oral and parenteral administration, the parenteral administration will determine the delivery code. The exclusively oral chemotherapy delivery code will be assigned to those regimens made up of only drugs administered orally and the costs should reflect current practice in light of the recommendations within the NPSA report on oral chemotherapy[4]

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

428 Chemotherapy costs and activity should be split by the following categories:

- Ordinary Admission (Elective or Non-Elective)
- Day Case and Regular Day/Night
- Outpatient, and
- Other

Please note, it is not expected that much, if any activity will appear in the other category, although this remains in the collection for consistency with other areas.

The different elements of the Admitted Patient Care category are disaggregated to better reflect the consistency in coding guidance for these areas.

Please note that the HRG4 Reference Cost Grouper will provide one unbundled HRG for each regimen procurement and one unbundled HRG per delivery not per attendance. Although rare, some patients may have 2 regimens delivered at one attendance which results in 2 delivery HRG's per attendance. An example of where this can happen 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 having. A patient may receive both an infusion plus oral treatment as part of a single regimen on the same day; this will be counted as one delivery and coded to an IV delivery code. It should be noted that patients may receive other IV and oral non – chemotherapy drugs for their cancers on the same day as their chemotherapy regimen e.g. administration of bisphosphonates, and the costs of these should not be included with the chemotherapy HRG but **should be attributed elsewhere**.

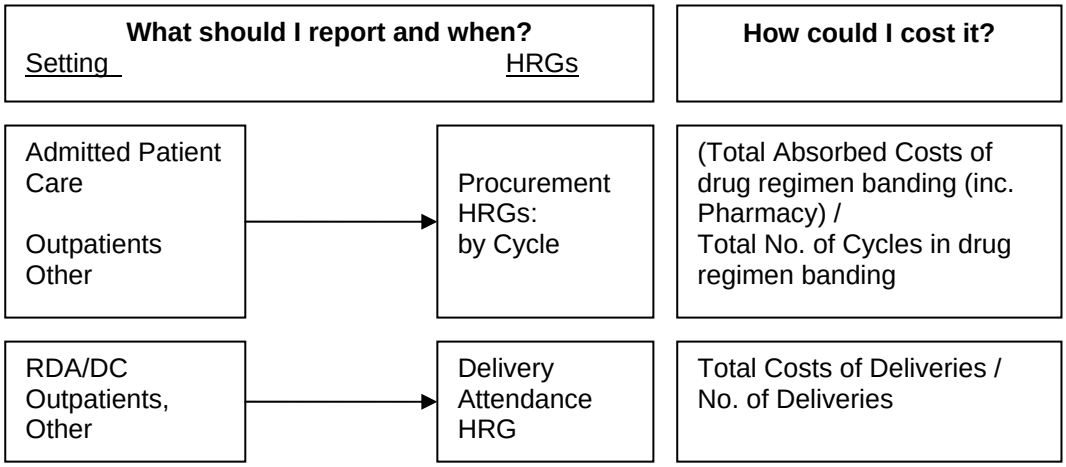
Table 10: Reporting of Chemotherapy

Chemotherapy HRG4	**Setting**	**Unit for Grouper Output**	**Unit Reference Costs reporting**
Drug banding HRGs (SB01Z to SB10Z)	Ordinary admission (elective or non-elective), regular day/night admissions, day case, outpatients, other	Procurements	Per average Cycle of treatment
Delivery HRGs (SB11Z to SB15Z)	Regular day/night admissions, day case, outpatients, other	Delivery	Delivery
Same day chemotherapy attendance/admission (SB97Z)	Day case, regular day/night admissions, day case, outpatients	Attendance/admission	

429 The table above lists the Chemotherapy HRGs and which settings these should be reported. Please note, if you are using the HRG4 2010-11 Reference Costs Grouper, there is a difference in the units of activity output from the Grouper and the units required in Reference Costs (final column) as shown in Diagram 2 below. The output of the Grouper will give number of procurements, the reference costs return asks for average cost of a cycle. See diagram below for information on how to cost.

430 Delivery HRGs. For the delivery HRGs (SB11Z to SB15Z), the following additional definitions may help organisations with their costing.

Definition	Explanation
Deliver simple parenteral chemotherapy	**Overall time of 30 minutes nurse time and 30 – 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 2 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 1st 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.**

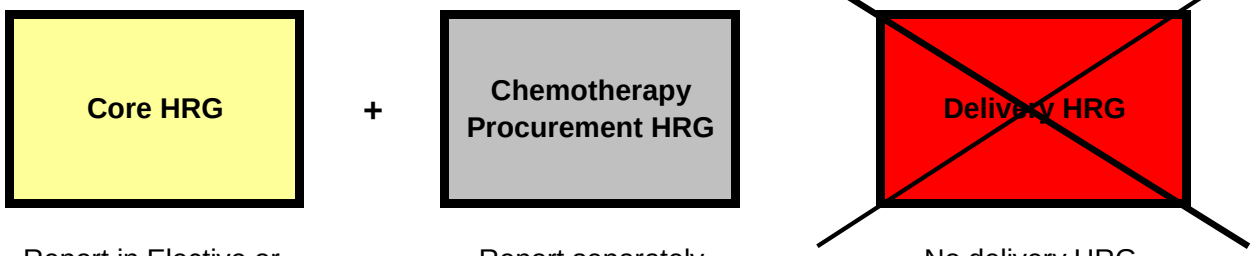


431 **Please note, to maintain consistency with national coding guidance, the OPCS procurement and delivery codes for chemotherapy should only be used where the treatment is for systemic anti-cancer therapy, i.e. malignancy and not for the treatment of non-malignant conditions. Certain drugs can appear 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. High cost drugs used in the treatment of non-neoplastic conditions should be coded using the high cost drugs codes and not the procurement and delivery codes**

Ordinary Admission (Elective or Non-Elective)

432 Ordinary admission (elective or non-elective) data for chemotherapy should be reported separately from regular day/night and daycase chemotherapy activity. For chemotherapy ordinary admission (elective or non-elective) you should report the activity and costs of the core HRG and the relevant chemotherapy procurement HRGs (where generated – one per spell). Delivery HRGs will not be generated for ordinary admission (elective or non-elective) data as OPCS delivery codes are not recorded for ordinary admission (elective or non-elective). The costs for this activity should be included within the core HRG generated.

Chemotherapy Ordinary Admission (Elective or Non Elective)



Report in Elective or Non-Elective sheet

Report separately when generated

No delivery HRG reported as not coded

Example 1 – Elective Ordinary Admissions

Table 11: Chemotherapy example 1
Please note, assumptions have been made for the purpose of this exercise.

	Diagnosis 1	Procedure 2 (Chemo regimen)	Procedure 3 (Chemo delivery)
ICD-10 OPCS (input)	C62.9 Malignant neoplasm of testis unspecified	X70.3 (Procure Drugs for Chemo, Band 3) Regimen: BEP 360 (Bleomycin, ectoposide & cisplatin)	Not coded
HRG (output)	LB35B Scrotum, Testis or Vas Deferens Disorders without CC	SB03Z (unbundled chemo regimen HRG)	Not coded

From the table above:

- The episode derives a core HRG of LB35B that is reported as 'Elective' activity.

- **The episode gets an additional unbundled HRG SB03Z for the chemo regimen (drug procurement) which is reported as part of the 'average cycle of treatment' for reference cost purposes.**

- No delivery output.

- Please note that current clinical coding guidance states, the only time 'Delivery' is recorded for Chemotherapy is when it is daycase, outpatient or a regular day attender, including when the chemotherapy delivery happens at a daycase setting and the patient is subsequently admitted (therefore generating an APC HRG).

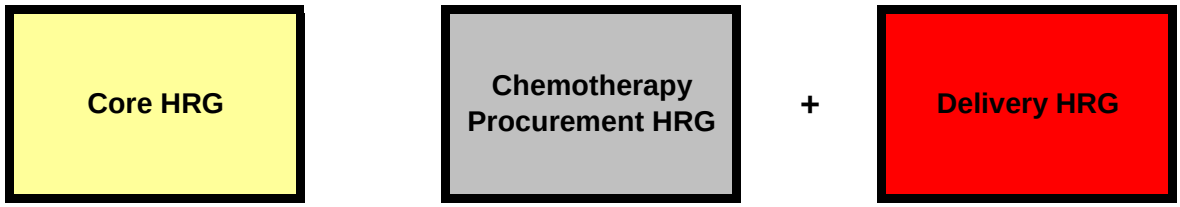
Day Case and Regular Day/Night

433 **As in the 2009/10 collection, a daycase/regular day/night patient admitted 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 should be reported using the HRG code SB97Z (sameday chemotherapy admission/attendance) if a patient has been admitted for a same day chemotherapy treatment. Prior to 2009/10, this activity was excluded. It is expected that there**

will be a zero cost submitted for this activity in the submission files. However, any nominal costs should be costed under full absorption principles.

434 Please be mindful when using SB97Z that if the HRG4 2010-11 Reference Costs Grouper length of stay is zero you may need to add 1 for length of stay if you are costing on a length of stay basis.

Day Case and Regular Day/Night Attenders



Report SB97Z | Report separately | Report separately if recorded

Example 2 – Day Case (First attendance of second cycle)

Table 12: Chemotherapy example 2

	Diagnosis 1	Procedure 1	Procedure 2 (Chemo regimen)	Procedure 3 (Chemo delivery)
ICD-10 OPCS (input)	C62.9 Malignant neoplasm of testis unspecified	N/A	X70.3 (Procure Drugs for Chemo, Band 3) Regimen: BEP 360 (Bleomycin, ectoposide & cisplatin)	X72.1 (Deliver complex chemotherapy for neoplasm inc prolonged infusional treatment
HRG (output)	N/A	SB97Z Same day chemotherapy admission/attendance	SB03Z (unbundled chemo regimen HRG)	SB14Z (unbundled chemo delivery HRG)

From the table above:

- - If there are **no other procedures** within the episode, the episode derives a core HRG of SB97Z reported as 'Day Case' activity. All of the Chemotherapy costs should be reported using the procurement or delivery HRGs

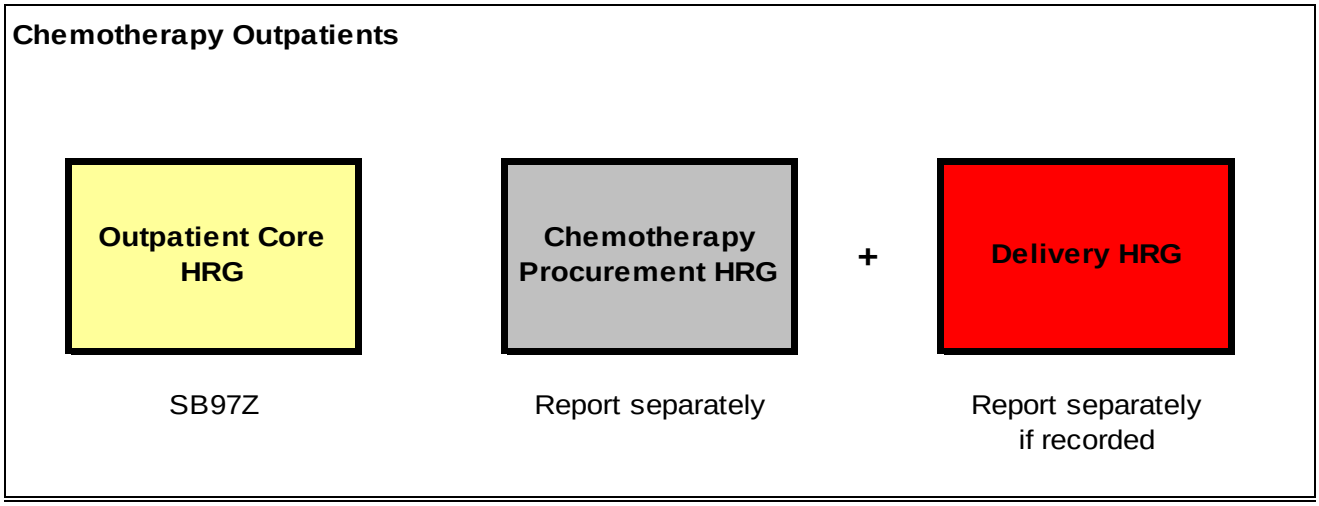
- The episode gets an additional unbundled HRG of SB03Z for the chemotherapy procurement, reported as part of the 'average cycle of treatment' for reference cost purposes.

- The episode gets a further unbundled HRG of SB14Z for chemo delivery, which is reported as 'a delivery per patient attendance' for reference costs.

Outpatients

435 **An Outpatient 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). Please note as in 2009/10, the core HRG should also now be reported using the code SB97Z (Same day chemotherapy admission/attendance) if a patient has attended for a same day/outpatient chemotherapy treatment ONLY. It is expected that there will be a zero cost submitted for this activity in the submission files. However, any nominal costs should be costed under full absorption principles.**

436 **Please note that for outpatient attendances, where the patient does not receive chemotherapy, e.g. pre treatment attendances, this should be recorded as a standard outpatient attendance not a chemotherapy attendance.**



Example 3 – Outpatient (First attendance of second cycle)

Table 13: Chemotherapy example 3

	Procedure 1	Procedure 2 (Chemo regimen)	Procedure 3 (Chemo delivery)
OPCS 4.5 (input)	**N/A**	**X70.3 (Procure Drugs for Chemo, Band 3) Regimen: BEP 360 (Bleomycin, ectoposide & cisplatin)**	**X72.1 (Deliver complex chemotherapy for neoplasm inc prolonged infusional treatment)**
HRG (output)	**SB97Z – Same day Chemotherapy admission/attendance**	**SB03Z (unbundled chemo regimen HRG)**	**SB14Z (unbundled chemo delivery HRG)**

As per daycase, for outpatient attendance the following can be summarised from the table above:

- If there are **no other procedures** within the episode, the episode derives a core HRG of SB97Z reported as 'Outpatient activity'. All of the Chemotherapy costs should be reported using the procurement or delivery HRGs

- The episode gets an additional unbundled HRG SB01Z for the chemotherapy procurement, which is reported as part of the 'average cycle of treatment' for reference cost purposes.

- The episode gets a further unbundled HRG SB14Z for chemotherapy delivery, which is reported as a delivery per patient attendance for reference costs. Remember subsequent attendances for the oral delivery of chemotherapy drugs should **also** be reported as SB11Z (and **not** SB15Z)

437 Where a chemotherapy outpatient attendance does not include any treatment then it should be recorded in the relevant consultation only code (WF – Prefixed) by the relevant Treatment Function e.g. 370 Medical Oncology (Attendance without Treatment) or 800 Clinical Oncology (Attendance without Treatment).

Other

438 If you have activity that does not fit into the definition of elective, non-elective, day case, regular day/night or outpatient activity, please report under the 'Other' category, reporting unbundled Chemotherapy delivery and Chemotherapy drug procurement HRGs.

Supportive and Hormonal Drug Treatment

439 Work is ongoing to resolve and clarify issues regarding the treatment of hormonal therapies and high cost supportive drugs, currently the treatment of such drugs should be as follows:

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 admission / outpatient attendance/procedure core HRG generated (not chemotherapy specific)	Apportion over procurement bands, potentially extra delivery time/costs
As part of supportive drug	Include costs within supportive drug costs	N/A

Costing

440 **Costs should be calculated and reported using full absorption costing principles. The cost of each drug procurement HRG (HRG SB01Z – SB10Z) should include pharmacy costs (including indirect costs and overheads) as well as all other costs associated with 'procuring' each drug cycle. The cost of supportive care drugs should be included within these HRGs also.**

441 The costs of delivering chemotherapy, for elective and non-elective ordinary admissions (elective or non-elective), should be reported as an on-cost to the ordinary admissions (elective or non-elective) admission 'core' HRG, as the ability to deliver chemotherapy is expected to be part of the routine care delivered on a ward.

442 For outpatients, day cases and regular day/night admissions, the cost of delivery should be reported against the relevant work type and against the appropriate chemotherapy 'delivery' HRG (SB11Z to SB17Z) on a full absorption cost basis. **Please note** same day attendance of SB97Z will also now be generated see paragraph 433 for further details.

443 HRG4 SB11Z 'Deliver exclusively oral chemotherapy' (see table 9) is used for any (not just the first) Oral Chemotherapy Delivery (subsequent attendances for this delivery are not be reported as SB15Z).

444 Supportive care costs for cancer patients should be allocated according to the matching principle as detailed in the NHS costing manual. Therefore;

- the costs of services directly related to the treatment of cancer, prior and subsequent to surgery, should be allocated to the appropriate surgical HRG; &

- those supportive care costs that are not associated with the surgical procedure should be allocated to non-surgical cancer HRG.

  This is to ensure a consistent approach to the allocation of supportive costs for cancer chemotherapy and surgery.

Additional Coding Information

445 **It is important that coders use the most up to date OPCS code set to record chemotherapy, this can be found on the CFH website The OPCS4.5 to HRG4 mapping, available in the Code to Group table (published on the IC Casemix website) can then be used to determine which OPCS code maps to which HRG4 Chemotherapy procurement HRG.**

446 To aid costing, Clinical Coding or Pharmacy departments should be able to supply a list of different regimens linked to OPCS 4.5 codes (which link to HRG4 bands) including average cycle lengths and which drugs are normally used in each regimen.

Additional Note - Chemotherapy Regimens

447 **The 2010-11 Reference Costs Grouper will identify a drug as either a chemotherapy procurement or high cost drug unbundled HRG, depending on the underlying coding guidance which links a specific drug to an OPCS code. The 'Delivery Attendance' chemotherapy HRG4 categories should be used to report any other costs incurred as a result of delivering the regimen outside of an ordinary admission (elective or non-elective) setting.**

448 For organisations using local data sources (not the HRG4 Reference Costs Grouper), a mapping of the regimens to OPCS 4.5 codes for procurement of chemotherapy drugs can be found at via the Connecting For Health website.

Exclusion

449 Please note that trial activity demonstratively funded by commercial companies (including free drugs, etc) should be excluded from the Reference Cost submission. The drug costs will not be incurred by the Trust and other associated trials costs should be excluded from the submission as listed within section 16 of the current guidance.

High Cost Drugs

450 All High Cost Drug HRGs within the Admitted Patient Care, Outpatient and Critical Care settings are unbundled. Whenever a separate High Cost Drug OPCS code is recorded, it will generate a separate unbundled High Cost Drug HRG in addition to the core HRG for the care episode.

HRGs & Units of activity

451 As with the treatment of most other separately identified services, High Cost Drugs should be separately identified from Admitted Patient Care (including Critical Care) and Outpatient services and reported using the HRG4 High Cost Drugs list and split by the following 3 categories:

- APC - Ordinary Admission (Elective or Non-Elective), Day Case and Regular Day/Night
- Outpatient and
- Other

452 The Unit of activity and costs in 2010-11 Reference Costs for High Cost Drugs HRG4s, are as follows:

Table 14: Reporting of High Cost Drugs

Setting	High Cost Drug HRG4s	Activity	Unit Cost
APC	XD01Z to XD38Z (excluding XD35Z and XD36Z)	Usage (HRGs) i.e. whenever a High Cost Drug OPCS code is recorded a High Cost Drug HRG is generated	**Per Average Spell**
Outpatients, Other	XD01Z to XD38Z (excluding XD35Z and XD36Z)	Usage (HRGs)	Per Average Attendance

453 Current coding guidance states that HCD are coded per Hospital provider spell and not FCE (page X-27, OPCS-4 Clinical Coding Instruction Manual V2.0), usually assigned in the first episode where the drug is administered (delivered). e.g. if a patient receives a particular HCD 10 times in a spell, code once. This should result in one unbundled HCD HRG from the HRG4 2010-11 Reference Costs Grouper per drug, per spell.

454 Should a patient receive two different HCDs within a single spell, then these would be coded separately (page X-27 OPCS-4 Clinical Coding Instruction Manual V2.0 (and output by the Grouper separately)), once for HCD1 and the once for HCD2.

455 However, it is **also** possible for the Grouper to output more than one of the same type of HCD HRG in a single spell. This may happen if more than one of the same type of HCD is administered to a patient. For example, a patient can receive both 'Infliximab' and 'Adalimumab' in a single spell, both of these belong to the same type of HCD (X92.1 Cytokine inhibitor drug Band 1). Coding guidance states that in this instance it would be legitimate to record both drugs even though the same OPCS-4.5 codes is used twice as these are different drugs (page X-27 Clinical Coding Instruction Manual V2.0), hence this would show as more than one unbundled HRG (i.e. 2 XD31Z HRGs produced by the Grouper).

456 The current 'High Cost Drug' (HCD) HRG design does **not take consideration of dosage** at all. Therefore, taking this, and the coding details above into consideration, to ensure that the cost and activity is recorded consistently, the **average cost of a high cost drug should be identified across the spell (or attendance)**. This reflects the fact that this spell/attendance includes the use of a HCD.

APC - Ordinary Admission (Elective or Non-Elective), Day Case and Regular Day/Night

457 For APC High Cost Drug activity, you should report the HRGs as produced by the HRG4 Reference Cost Grouper and report the cost (which includes relevant pharmacy costs as well as all the other costs associated with procuring each drug) on an average activity / cost per spell basis.

Example 1 – Elective Ordinary Admission (Elective or Non-Elective)

Table 15: HCD example 1

Case	Primary Diagnosis	Procedure 1	HRG
A	I27.0 Pulmonary hypertension	X866 Antiretroviral drugs Band 1 (Abacavir administered)	Core HRG EB01Z Non interventional acquired cardiac conditions 19 years and over + High cost drug HRG XD38Z Antiviral drugs Band 1

From the table above:

- The first episode/spell derives a core HRG of EB01Z reported as 'Elective' activity.
- This episode/spell generates an additional unbundled HRG XD38Z for the high cost drug recorded in the episode (single FCE), which is included in a calculation to work out 'the unit cost of a high cost drug per average spell' for reference cost purposes.
- The same procedure and HCD (Abacavir) occurs in a 2nd and 3rd episode/spell
- In another spell, both 'Abacavir' and 'Amprenavir' are administered to patient i.e. 2 high cost drug HRGs are coded

Calculation from above for Reference Costs (based on only 4 spells take place in year)

		HCD X866 Instances/HRGs	Total Cost £
Spell 1		1	400
Spell 2		1	390
Spell 3		1	395
Spell 4	*	2	765
Total		5	1,950

Reported Activity	Reported Unit Cost
5 HCD HRGs	**£390.00 average unit cost /HCD HRG**

* It may be possible to have the same High Cost Drug HRG within the same spell where different drugs assigned to the same code are delivered.

Outpatients

458 For Outpatient High Cost Drug activity, you should report the HRGs as produced by the HRG4 Reference Cost Grouper and report the cost on an average activity / cost per attendance basis.

'Other'

459 For 'Other' High Cost Drug activity not captured as admitted, outpatient or direct access, stand-alone pharmacy data system should be used in the absence of clinical coding to try and derive the appropriate OPCS code and thus generate the HRG as appropriate and reported on a '**per average attendance' basis**.

Costing

460 Costs should be calculated and reported using full absorption costing principles. The costs of each High Cost Drug HRG4 should include relevant **pharmacy costs** as well as all other costs associated with **'procuring' each drug**, but not with administering. The associated drug costs (costs of drugs that are administered with the high cost drugs) and administering costs **should not be** included in the costs of the high cost drugs reported. These costs should remain in the 'core' HRG costs.

461 For APC, the High Cost Drug HRG4 costs should be separated from the Ordinary Admission (Elective or Non-Elective) or Daycase 'Core' HRG4 costs.

462 The costs of any outpatient attendance (not including the cost of High Cost Drugs) should be reported separately as Outpatient activity (see section 3).

Additional Coding Information

463 OPCS high cost drug codes need to be recorded to generate the correct HRG. It is important that clinicians and the pharmacy department clearly identify the use of specified high cost drugs in clinical notes and ensure that this information is communicated to coding staff. Where organisations currently use the discharge summary to code, they should ensure that the names of the drugs are clearly documented on the summary.

464 Failure to record the correct OPCS codes for high cost drug use may lead to incorrect identification of resource usage and a failure to generate an unbundled HRG.

465 For reporting High Cost Drugs separately in Reference Costs, you should only separately identify the Drugs in the HRG4 categories (and the OPCS codes that feed into these categories – using the code to group table).

466 **Annex D** gives details on where to find the mapping from high cost drug to OPCS-4.5 code to HRG.. Please note, **as per previous years**, Please note, **as per previous years**, the HRGs XD35Z and XD36Z have been removed from the collection as no high cost drugs map to these HRGs.

Statement Z HCD Information

467 Please note that there are some high cost drugs that are on a tariff exclusion list that were not "unbundled" in 2009/10 i.e. not reported separately on the Reference Costs 2009/10 HRG4 list (or underlying OPCS table) shown in **Annex E** of this document.

468 Those drugs listed in **Annex E** should only be recorded in **Statement Z** where they do not relate to chemotherapy for neoplasms, i.e. the drugs should not be recorded in **Statement Z** when they are for a neoplasm diagnosis. Certain drugs appear in both the OPCS-4.5 High cost drugs list and chemotherapy regimens list because they can be used to treat neoplasms in addition to a range of other conditions. Examples include: Rituximab and Thalidomide. High cost drugs used in the treatment of neoplasms should be coded using the chemotherapy regimens list and not the High cost drugs list.

Diagnostic Imaging (Radiology)

HRGs & Units of activity

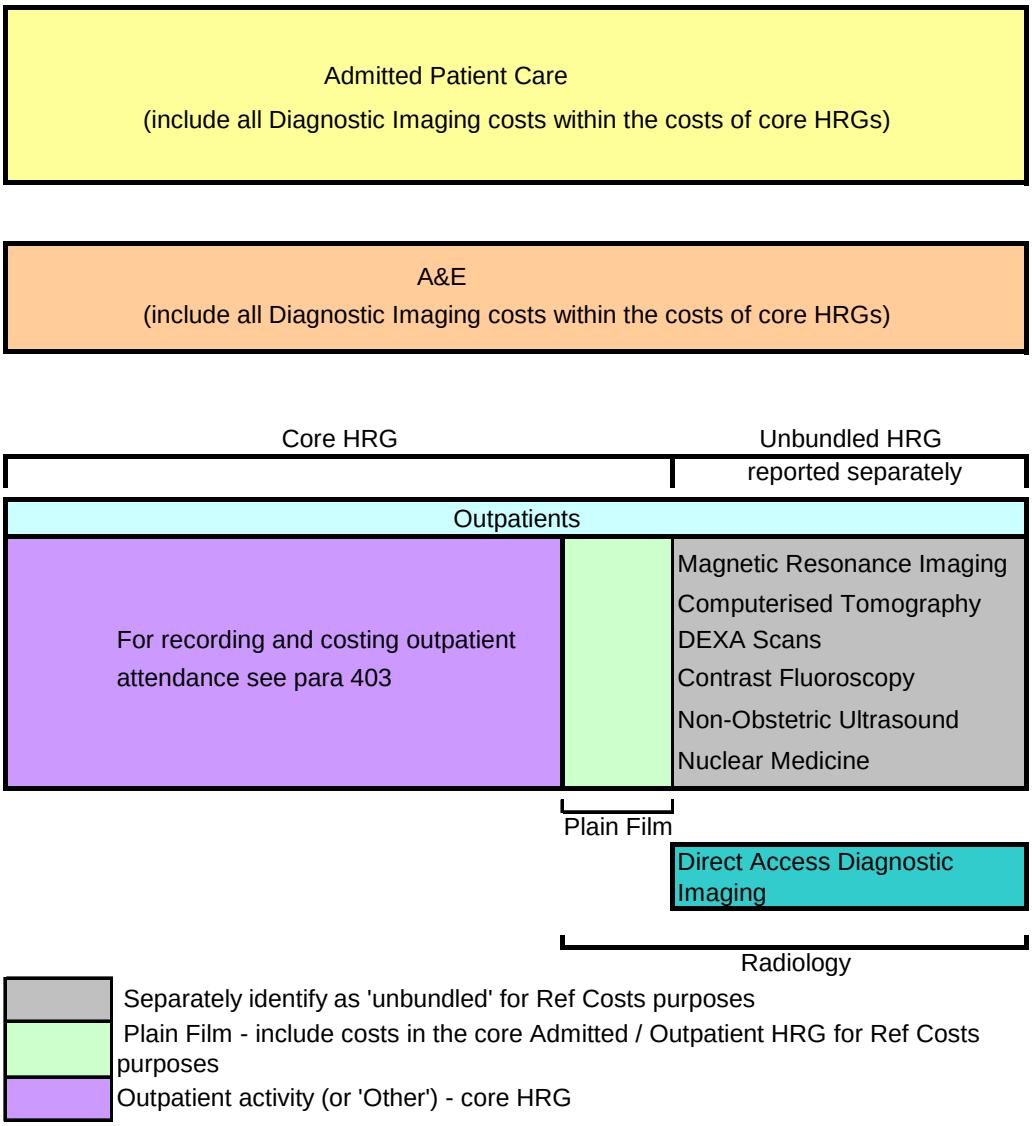
469 For Diagnostic Imaging (Radiology) HRG4s, the unit of activity is examinations. For example, someone who attends for an orthopaedic attendance, and has three MRIs examinations (scans), would be recorded and costed as three MRIs, plus the 'core' orthopaedic attendance HRG.

470 It should however be noted that individual HRGs may account for scans of multiple body areas within the same visit to a scanner (for example RA05Z – Computerised Tomography Scan, three areas without contrast) i.e. one scan should equal one HRG (but the scan may be of multiple body parts).

471 For the 2010-11 collection, Diagnostic Imaging (radiology) services costs/activity should be should be reported under the following settings (Please note this does not include Interventional Radiology – See below):

- Outpatient (including Direct Access – see paragraph 477); and
- Other (anything other than APC, A&E, Outpatients and Direct Access)

Table 16 – Diagnostic Imaging



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Admitted Patient Care

472 Please note, **as with previous years,** all Admitted Patient Care (Ordinary Elective, Ordinary Non-Elective, Day Case and Regular Admissions) Diagnostic Imaging costs (and activity) should not be unbundled i.e. it should be included within the core HRG (see below).

473 Therefore, any unbundled Diagnostic Imaging HRGs produced ("unbundled") by the HRG4 Reference Cost Grouper for Admitted Patient Care should be ignored and the costs reported within the core HRG.

474 Any Diagnostic Imaging Imaging undertaken while a patient is an Inpatient (irrespective of whether they are in critical care) is part of the Admitted Patient Care Pathway, will be recorded on the APC record, and costed into the APC HRG, not the Critical care period. Do not report any diagnostic imaging activity separately for Critical Care.

Outpatients

475 Please note that, **as per 2009-10**, Diagnostic Imaging previously reported under Outpatients will now be split between Diagnostic Imaging services accessed directly, and those accessed as a part of an outpatient attendance. Please see paragraphs 404-405 for more information on reporting Diagnostic Imaging accessed directly.

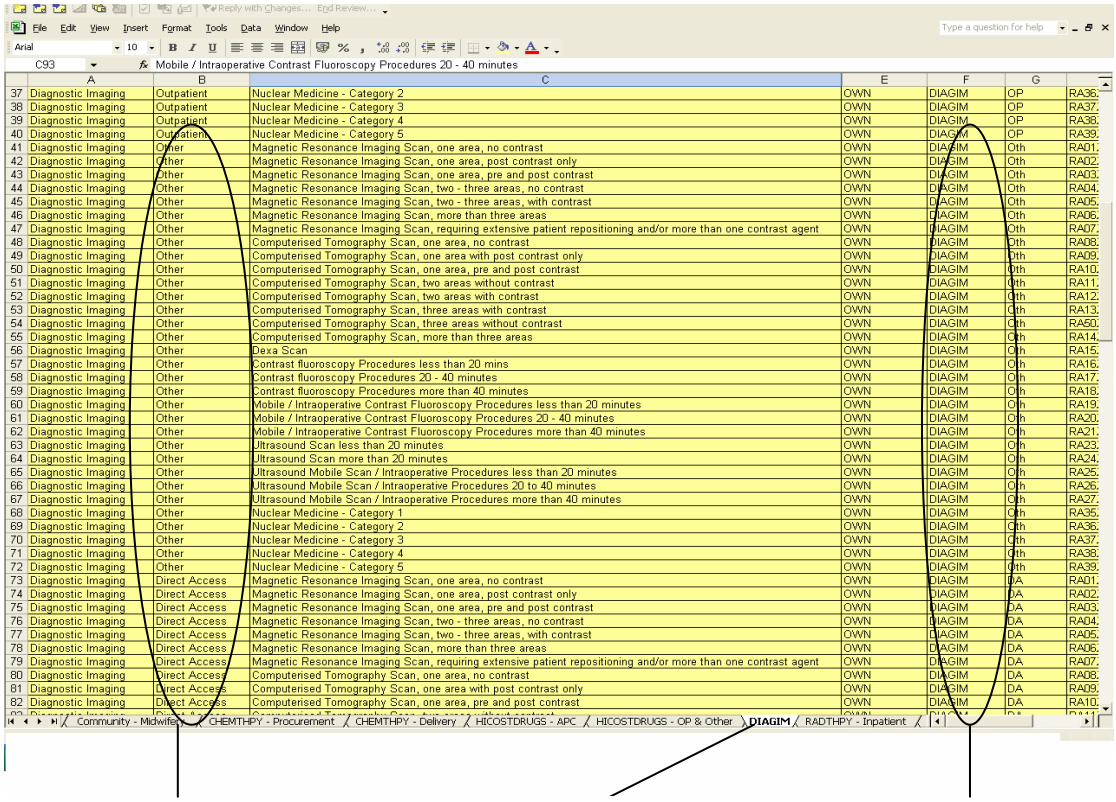
476 For Outpatient activity, where no other procedures are recorded, as well as the 'Diagnostic Imaging' unbundled HRGs, the HRG4 Reference Cost Grouper will also output a 'core' Outpatient attendance HRG (WF01 / WF02). Any Outpatient attendance should be recorded and costed separately. However, where a patient attends for Diagnostic Imaging only, you **should not** report a separate 'core' Outpatient attendance.

477 To note, where organisations provide imaging services to another Trust, the organisation who requests the activity (and is recharged for it) should include them in reference costs, and the provider nets off the income received from the commissioner.

Direct Access - Diagnostic Imaging

478 There are numerous occasions when Diagnostic Imaging is carried out independently of other types of care, for example where a patient has been referred by a GP or other healthcare professional. This activity is classified, for Reference Costs purposes, as 'Direct Access' or 'Services Accessed Directly', relating to all sources of referral for diagnostic tests and services outside the APC, Outpatient, A&E and Critical Care settings.

479 Please report all unbundled Direct Access Diagnostic Imaging in the **Diagnostic Imaging** reporting worksheet (**DIAGIM**). Within this 'pre-populated' worksheet, there are a number of reporting lines for the unbundled Diagnostic Imaging HRG4 categories in different patient settings. Please report all unbundled Direct Access Diagnostic Imaging in the Direct Access setting lines against the appropriate HRG4 code/description (shown below):



	A	B	C	E	F	G	
37	Diagnostic Imaging	Outpatient	Nuclear Medicine - Category 2	OWN	DIAGIM	OP	RA36.
38	Diagnostic Imaging	Outpatient	Nuclear Medicine - Category 3	OWN	DIAGIM	OP	RA37.
39	Diagnostic Imaging	Outpatient	Nuclear Medicine - Category 4	OWN	DIAGIM	OP	RA38.
40	Diagnostic Imaging	Outpatient	Nuclear Medicine - Category 5	OWN	DIAGIM	OP	RA39.
41	Diagnostic Imaging	Other	Magnetic Resonance Imaging Scan, one area, no contrast	OWN	DIAGIM	Oth	RA01.
42	Diagnostic Imaging	Other	Magnetic Resonance Imaging Scan, one area, post contrast only	OWN	DIAGIM	Oth	RA02.
43	Diagnostic Imaging	Other	Magnetic Resonance Imaging Scan, one area, pre and post contrast	OWN	DIAGIM	Oth	RA03.
44	Diagnostic Imaging	Other	Magnetic Resonance Imaging Scan, two - three areas, no contrast	OWN	DIAGIM	Oth	RA04.
45	Diagnostic Imaging	Other	Magnetic Resonance Imaging Scan, two - three areas, with contrast	OWN	DIAGIM	Oth	RA05.
46	Diagnostic Imaging	Other	Magnetic Resonance Imaging Scan, more than three areas	OWN	DIAGIM	Oth	RA06.
47	Diagnostic Imaging	Other	Magnetic Resonance Imaging Scan, requiring extensive patient repositioning and/or more than one contrast agent	OWN	DIAGIM	Oth	RA07.
48	Diagnostic Imaging	Other	Computerised Tomography Scan, one area, no contrast	OWN	DIAGIM	Oth	RA08.
49	Diagnostic Imaging	Other	Computerised Tomography Scan, one area with post contrast only	OWN	DIAGIM	Oth	RA09.
50	Diagnostic Imaging	Other	Computerised Tomography Scan, one area, pre and post contrast	OWN	DIAGIM	Oth	RA10.
51	Diagnostic Imaging	Other	Computerised Tomography Scan, two areas without contrast	OWN	DIAGIM	Oth	RA11.
52	Diagnostic Imaging	Other	Computerised Tomography Scan, two areas with contrast	OWN	DIAGIM	Oth	RA12.
53	Diagnostic Imaging	Other	Computerised Tomography Scan, three areas with contrast	OWN	DIAGIM	Oth	RA13.
54	Diagnostic Imaging	Other	Computerised Tomography Scan, three areas without contrast	OWN	DIAGIM	Oth	RA50.
55	Diagnostic Imaging	Other	Computerised Tomography Scan, more than three areas	OWN	DIAGIM	Oth	RA14.
56	Diagnostic Imaging	Other	Dexa Scan	OWN	DIAGIM	Oth	RA15.
57	Diagnostic Imaging	Other	Contrast fluoroscopy Procedures less than 20 mins	OWN	DIAGIM	Oth	RA16.
58	Diagnostic Imaging	Other	Contrast fluoroscopy Procedures 20 - 40 minutes	OWN	DIAGIM	Oth	RA17.
59	Diagnostic Imaging	Other	Contrast fluoroscopy Procedures more than 40 minutes	OWN	DIAGIM	Oth	RA18.
60	Diagnostic Imaging	Other	Mobile / Intraoperative Contrast Fluoroscopy Procedures less than 20 minutes	OWN	DIAGIM	Oth	RA19.
61	Diagnostic Imaging	Other	Mobile / Intraoperative Contrast Fluoroscopy Procedures 20 - 40 minutes	OWN	DIAGIM	Oth	RA20.
62	Diagnostic Imaging	Other	Mobile / Intraoperative Contrast Fluoroscopy Procedures more than 40 minutes	OWN	DIAGIM	Oth	RA21.
63	Diagnostic Imaging	Other	Ultrasound Scan less than 20 minutes	OWN	DIAGIM	Oth	RA23.
64	Diagnostic Imaging	Other	Ultrasound Scan more than 20 minutes	OWN	DIAGIM	Oth	RA24.
65	Diagnostic Imaging	Other	Ultrasound Mobile Scan / Intraoperative Procedures less than 20 minutes	OWN	DIAGIM	Oth	RA25.
66	Diagnostic Imaging	Other	Ultrasound Mobile Scan / Intraoperative Procedures 20 to 40 minutes	OWN	DIAGIM	Oth	RA26.
67	Diagnostic Imaging	Other	Ultrasound Mobile Scan / Intraoperative Procedures more than 40 minutes	OWN	DIAGIM	Oth	RA27.
68	Diagnostic Imaging	Other	Nuclear Medicine - Category 1	OWN	DIAGIM	Oth	RA35.
69	Diagnostic Imaging	Other	Nuclear Medicine - Category 2	OWN	DIAGIM	Oth	RA36.
70	Diagnostic Imaging	Other	Nuclear Medicine - Category 3	OWN	DIAGIM	Oth	RA37.
71	Diagnostic Imaging	Other	Nuclear Medicine - Category 4	OWN	DIAGIM	Oth	RA38.
72	Diagnostic Imaging	Other	Nuclear Medicine - Category 5	OWN	DIAGIM	Oth	RA39.
73	Diagnostic Imaging	Direct Access	Magnetic Resonance Imaging Scan, one area, no contrast	OWN	DIAGIM	DA	RA01.
74	Diagnostic Imaging	Direct Access	Magnetic Resonance Imaging Scan, one area, post contrast only	OWN	DIAGIM	DA	RA02.
75	Diagnostic Imaging	Direct Access	Magnetic Resonance Imaging Scan, one area, pre and post contrast	OWN	DIAGIM	DA	RA03.
76	Diagnostic Imaging	Direct Access	Magnetic Resonance Imaging Scan, two - three areas, no contrast	OWN	DIAGIM	DA	RA04.
77	Diagnostic Imaging	Direct Access	Magnetic Resonance Imaging Scan, two - three areas, with contrast	OWN	DIAGIM	DA	RA05.
78	Diagnostic Imaging	Direct Access	Magnetic Resonance Imaging Scan, more than three areas	OWN	DIAGIM	DA	RA06.
79	Diagnostic Imaging	Direct Access	Magnetic Resonance Imaging Scan, requiring extensive patient repositioning and/or more than one contrast agent	OWN	DIAGIM	DA	RA07.
80	Diagnostic Imaging	Direct Access	Computerised Tomography Scan, one area, no contrast	OWN	DIAGIM	DA	RA08.
81	Diagnostic Imaging	Direct Access	Computerised Tomography Scan, one area with post contrast only	OWN	DIAGIM	DA	RA09.
82	Diagnostic Imaging	Direct Access	Computerised Tomography Scan, one area, pre and post contrast	OWN	DIAGIM	DA	RA10.

Outpatient/Direct Access/Other Setting

Worksheet = DIAGIM

HRG4 = Unbundled Diagnostic Imaging

'Other'

480 To clarify, any activity that is not Admitted Patient Care, A&E, Outpatients and Direct Access should be reported under the 'Other' setting (see diagram above).

Further Information Specific to Diagnostic Imaging

Radiology not "unbundled" by the HRG Reference Cost Grouper

481 Please note, certain diagnostic imaging would not be coded in a way that would generate an unbundled Diagnostic Imaging HRG. For example, where an obstetric ultrasound is correctly coded, it is likely that it will produce a core HRG of either NZ05 or NZ08 rather than the activity being recorded against a 'core' outpatient attendance HRG (WF01 / WF02). For Reference Cost purposes, the cost (and activity) for these scans should not be unbundled, and instead **reported within the outputted core HRG**.

Plain Film X-Rays – treated differently

482 Plain film x-ray activity and costs are **not** unbundled from either 'Outpatients' or 'Other' (i.e. costs are included with core HRG activity) due to the high frequency, low cost nature of this service. To clarify, the 2010-11 HRG4 Reference Cost Grouper will not unbundle any plain film activity, the composite costs should be included within the core HRG (which may be a core outpatient attendance HRG [WF01/WF02]) irrespective of patient setting.

Direct Access – Plain Film

483 Please Note: In addition to the above, as per 2009-10 guidance and in order to support future Tariff development, Direct Access plain film x-ray should be reported using the **Outpatient Attendance** worksheet of the 2010-11 Reference Cost main collection workbook, as follows:

Using the appropriate data type (own, commissioned or contracted out)

- As Consultant Led activity
- Under Treatment Function Code DAPF (Diagnostic Access Plain Film)
- Attributed to HRG WF01B (Non-Admitted Face to Face First Attendance)

484 As per paragraph above, direct access plain film x-ray activity should be recorded against TFC 'DAPF'. Outpatient attendance HRG. Non-direct access plain film x-ray activity should be recorded against the relevant 'core' HRG produced from the HRG4 2010-11 Reference Costs Grouper, as per the above.

Coding

485 Diagnostic Imaging (Radiology) HRGs are derived through the use of OPCS codes to capture procedures and interventions. The use of OPCS codes for recording all procedures and interventions, including radiology, was detailed in DSCN 04/2006, and a coding clinic document dated September 2006 (Volume 3 Issue 6). It is therefore expected that radiology activity will be recorded using OPCS codes as per the DSCN.

486 Please note, a coding clinic document dated 1st October 2008 (DSCN 02/2007) now supersedes DSCN 04/2006. This change was implemented to improve the coding sequence to resolve a previous issue with the HRG4 Reference Cost Grouper (i.e. the Grouper output will become more reflective of activity).

487 However, Radiology Departments generally have their own information systems, which may not necessarily be linked to PAS. Although Radiology stand-alone systems are clinical systems and so there should be lots of information within these systems to allow a good estimate of which OPCS code (and so HRG4 code) the activity would have been coded against. Providers will need to ensure that there is a mechanism in place to provide relevant information to clinical coders so that imaging procedures can be entered as OPCS codes on PAS.

488 The Draft National Interim Clinical Imaging Procedure (NICIP) code set is now available for download from The Terminology Reference-data Update Distribution service (TRUD) available from NHS CfH.

Costing

489 Diagnostic Imaging (Radiology) should be costed at the HRG4 level. However, it should be noted that individual HRGs may account for scans of multiple body areas within the same visit to a scanner (for example RA05Z – Computerised Tomography Scan, three areas without contrast) i.e. one scan should equal one HRG (but the scan may be of multiple body parts).

490 Costs for examinations should be calculated and reported using full absorption costing principles.

491 Where a patient has an Outpatient attendance, as well as the unbundled (Diagnostic Imaging) examination, the costs of the Outpatient attendance should be separately reported and costed. The costs of any Outpatient attendance (not including the cost of unbundled Diagnostic Imaging (Radiology)) should be reported separately as Outpatient activity (section 3). However, where a patient attends for unbundled Diagnostic Imaging only, you **should not** also report a separate 'core' Outpatient attendance.

Interventional Radiology –(no longer unbundled)

492 A new subchapter for Interventional Radiology HRGs have been created to support best practice tariff policy and to collect certain procedures that are predominantly undertaken using Interventional radiology. These Interventional Radiology HRGs are **no longer unbundled and are included within the core IR HRG reported.**

Radiotherapy

Introduction

493 **The Department is working closely with the Casemix Service from the NHS Information Centre (NHSIC), the National Cancer Action Team (NCAT). NHS Connecting For Health and national steering groups, in order to develop a national tariff for radiotherapy. The 2010-11 guidance for radiotherapy is mainly unchanged from previous years.**

494 Radiotherapy data reported as part of the reference costs process are fully reliant on the consistent and accurate recording of activity using the mandated OPCS classifications. It is therefore important that you work collaboratively with your information/coding/clinical leads in order to help this process.

495 **The introduction of the radiotherapy dataset in 2009 should be used by organisations as a source of data for organisations submitting Reference Costs.**

Guidance

496 Radiotherapy treatment costs should continue to be separated out of the composite costs of other treatments and shown separately.

497 HRGs for radiotherapy are to be used for reporting all of the costs and activity related to radiotherapy services, regardless of whether the patient is admitted or not. .

498 For the 2010-11 collection, and following feedback from the NHS, the radiotherapy costs and activity should be split by the following **4 categories** (Ordinary Admission (Elective or Non-Elective) data should continued to be separated from 'Other' activity (Day Case/RDA/Outpatient/Other) to aid consistency of reporting in line with coding rules):

- Ordinary Admission (Elective or Non-Elective)
- Day Case and Regular Day/Night
- Outpatient and
- Other

499 **It is not expected that much, if any activity will appear in the other category, although this remains for consistency with other areas.**

500 The radiotherapy HRGs are similar to the design of the Chemotherapy HRGs, in that an attendance for radiotherapy may result in an additional 2 radiotherapy HRGs being produced – one set for pre-treatment (planning) processes and one set for treatment delivered, with a separate code being allocated for each fraction delivered, only 1 fraction per attendance should be coded These HRGs are generated in addition to the core HRG that would be grouped for the admission/attendance. These groups are:

- Radiotherapy planning (SC40Z to SC57Z)

- Radiotherapy treatment (delivery per fraction). (SC21Z to SC31Z)

Radiotherapy Planning HRGs

SC40Z	**Preparation for intensity modulated radiation therapy**
SC41Z	**Preparation for intensity modulated radiation therapy-With Technical Support**
SC42Z	**Preparation for Total Body Irradiation**
SC43Z	**Preparation for Total Body Irradiation-With Technical Support**
SC44Z	**Preparation for hemi body irradiation**
SC45Z	**Preparation for simple radiotherapy with imaging and dosimetry**
SC46Z	**Preparation for simple radiotherapy with imaging and dosimetry-**

	With Technical Support
SC47Z	**Preparation for simple radiotherapy with imaging and simple calculation**
SC48Z	**Preparation for simple radiotherapy with imaging and simple calculation-With Technical Support**
SC49Z	**Preparation for superficial radiotherapy with simple calculation**
SC50Z	**Preparation for superficial radiotherapy with simple calculation-With Technical Support**
SC51Z	**Preparation for complex conformal radiotherapy**
SC52Z	**Preparation for complex conformal radiotherapy-With Technical Support**
SC53Z	**Preparation for intraluminal brachytherapy**
SC54Z	**Preparation for intracavitary brachytherapy**
SC55Z	**Preparation for interstitial brachytherapy**
SC56Z	**Other external beam radiotherapy preparation**
SC57Z	**Other brachytherapy preparation**

Radiotherapy Delivery HRGs

SC21Z	**Deliver a fraction of treatment on a superficial or orthovoltage machine**
SC22Z	**Deliver a fraction of treatment on a megavoltage machine**
SC23Z	**Deliver a fraction of complex treatment on a megavoltage machine**
SC24Z	**Deliver a fraction of radiotherapy on a megavoltage machine using general anaesthetic**
SC25Z	**Deliver a fraction of Total Body Irradiation**
SC26Z	**Deliver a fraction of intracavitary radiotherapy without general anaesthetic**
SC27Z	**Deliver a fraction of intracavitary radiotherapy with general anaesthetic**
SC28Z	**Deliver a fraction of interstitial radiotherapy**
SC29Z	**Other Radiotherapy Treatment**
SC30Z	**Deliver of a fraction of intraluminal brachytherapy**
SC31Z	**Deliver a fraction of adaptive Radiotherapy on a megavoltage machine**

501 For example, a first outpatient attendance may result in the two HRGs described, with the follow up attendances only resulting in the delivery HRGs being assigned (these in addition to the core HRG).

502 **The intention in HRG4 is that each fraction would be separately counted, rather than the number of courses of treatments. However, for ordinary admissions (elective or non-elective), coding guidance states that only one delivery fraction should be recorded per ordinary admissions (elective or non-elective) stay, so the unit of activity for ordinary admissions (elective or non-elective) is per admission (unless the patient has treatment to more than one body site and then it would be permissible to record a delivery fraction for each of the areas treated).**

The table below aims to clarify the output of the HRG4 2010-11 Reference Costs Grouper for the different patient groups (providing organisations have followed NHS Connecting for Health coding guidance) and the treatment of the data for reference costs reporting

Table : Radiotherapy Outputs

Patient Type	HRG Output from the Grouper	Treatment of HRG in Reference Costs
Ordinary Admission (Elective or Non-Elective)	Core HRG + Planning HRG (one coded per admission) + Delivery HRG (one coded per admission)	Report core HRG costs separately from radiotherapy costs Report planning costs using Planning HRGs Report all delivery costs for the admission using Delivery HRG
Day Case/Regular Day Attender	Core admission HRG + Planning HRG (one coded per course of treatment) + Delivery HRG (one coded per fraction delivered)	Ignore core admission HRG – all radiotherapy costs reported in planning or delivery activity. Report unit cost of planning HRG per course of treatment Delivery HRGs – Use to report average cost per fraction (and number of attendances)
Outpatients	Core Attendance HRG + Planning HRG (one coded per course of treatment) + Delivery HRG (one coded per fraction delivered)	Ignore core attendance HRG – all radiotherapy costs reported in planning or delivery activity. Report unit cost of planning HRG per course of treatment Delivery HRGs – Use to report average cost per fraction (and number of attendances)
Other	Category to be used for any activity not included in categories above	Report planning per course and delivery per fraction.

Example 1 – Outpatient

A patient is diagnosed as having Hodgkin's lymphoma. Prior to bone marrow transplant, the patient receives a 5-fraction course of total body irradiation (TBI). The TBI is planned and the first treatment is given immediately afterwards (same attendance):

Table 18: Radiotherapy Example 1

	1st Attendance	2nd Attendance	3rd Attendance	4th Attendance	5th Attendance
OPCS-4.5	X67.2 Preparation for total body irradiation X65.1 Delivery of a fraction of total body irradiation (TBI)	X65.1 Delivery of a fraction of total body irradiation (TBI)	X65.1 Delivery of a fraction of total body irradiation (TBI)	X65.1 Delivery of a fraction of total body irradiation (TBI)	X65.1 Delivery of a fraction of total body irradiation (TBI)
HRG	WF Prefixed Outpatient Attendance (Core) HRG + SC42Z Preparation for Total Body Irradiation + SC25Z Deliver a fraction of Total Body Irradiation	WF Prefixed Outpatient Attendance (Core) HRG + SC25Z Deliver a fraction of Total Body Irradiation	WF Prefixed Outpatient Attendance (Core) HRG + SC25Z Deliver a fraction of Total Body Irradiation	WF Prefixed Outpatient Attendance (Core) HRG + SC25Z Deliver a fraction of Total Body Irradiation	WF Prefixed Outpatient Attendance (Core) HRG + SC25Z Deliver a fraction of Total Body Irradiation

From the table above:

- **The episode derives a core HRG based on other procedures of the attendance or a consultation outpatient HRG (non-admitted consultations). The cost of which should be included as an overhead within the fraction cost (and the activity ignored).**
- **The first attendance generates additional unbundled HRGs for the radiotherapy preparation SC42Z and radiotherapy delivery SC25Z. The planning HRG is intended to cover all attendances required for completion of the planning process. It is not intended that individual attendances for parts of this process will be recorded separately.**
- **The planning HRG does not include the consultation at which the patient consents to radiotherapy, nor would it cover any outpatient attendance for medical review required by any change in status of the patient. This should be reported separately as appropriate outpatient activity.**
- **The subsequent attendances generate an unbundled radiotherapy delivery HRG SC25Z (and core OP HRG - to be ignored and costs for this applied to the fraction cost as an overhead).**

Example 2 Radiotherapy Treatment
A patient is diagnosed with Breast Cancer, which is typically treated by 25 fractions and one planning course, only one instance of treatment is shown in the example below.

	Diagnosis 1	Planning	Treatment (Radiotherapy delivery)
ICD-10 OPCS (input)	C50.9 Malignant neoplasm of breast, unspecified	X67.5 Preparation for simple radiotherapy with imaging and dosimetry	X65.4 Delivery of a fraction of external beam radiotherapy NEC
HRG (output)	JA12Z – Malignant breast disorders without CC	SC47Z – Preparation for simple Radiotherapy with imaging and simple calculation	SC29Z - Other Radiotherapy treatment

503 Please note that for **Delivery Costs** for day case/regular day and outpatient activity, we are not asking for an average unit cost per treatment course to be reported. For these patient types, **cost per fraction** should be reported by HRG. In addition, the number of relevant attendances/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.

To assist with costing the activity, definitions are available to describe the clinical assumptions applied by the Expert Working Group in the design of the Radiotherapy HRGs and may help to differentiate between 'simple' and 'complex' cases.

504 The radiotherapy HRGs and the underlying source data, flags and lists used to derive these HRGs can be found at the link below: (click on HRG4 Definitions (Zip, 14.5MB) and select 'sc radiotherapy listing')

http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/healthcare-resource-groups-4-hrg4

505 Supportive care costs for cancer patients should be allocated according to the matching principle as detailed in the NHS costing manual. Therefore;

- the costs of services directly related to the treatment of cancer, prior and subsequent to surgery, should be allocated to the appropriate surgical HRG4; &
- those supportive care costs that are not associated with the surgical procedure should be allocated to non-surgical cancer HRG4.

This is to ensure a consistent approach to the allocation of supportive costs for cancer radiotherapy and surgery.

506 Advice from NCAT highlights the need to allocate costs according to the type of Radiotherapy being delivered. There are predominantly two types of Radiotherapy:

- **External Beam Radiotherapy** and
- **Brachytherapy and Liquid Radionuclide administration**.

507 For more information on the detailed costing work undertaken by NCAT members, please visit

http://www.cancer.nhs.uk/radiotherapy/

Brachytherapy

508 **Work to develop the brachytherapy classification is ongoing with the Casemix Service team at the NHSIC and NCAT looking at the current HRGs. Until this work is complete, it is important that brachytherapy costs are only reported within the current set of brachytherapy HRGs.**

As indicated in the Radiotherapy Planning and Radiotherapy Delivery tables above, the HRGs

SC53Z	**Preparation for intraluminal brachytherapy**
SC54Z	**Preparation for intracavitary brachytherapy**
SC55Z	**Preparation for interstitial brachytherapy**
SC57Z	**Other brachytherapy preparation**
SC26Z	**Deliver a fraction of intracavitary radiotherapy without general anaesthetic**
SC27Z	**Deliver a fraction of intracavitary radiotherapy with general anaesthetic**
SC28Z	**Deliver a fraction of interstitial radiotherapy**
SC30Z	**Deliver of a fraction of intraluminal brachytherapy**

As work progresses in this area, more information will be available at the NCAT website, link above.

Rehabilitation Services

509 For the 2010-11 collection, the rehabilitation costs and activity will continue to be split by the following 3 categories:

- Ordinary Admission (Elective or Non-Elective)/Day Case/Regular Day (APC)
- Outpatient
- Other (any activity that does not fall into either of the above 2 categories)

HRGs & Units of activity

510 All Rehabilitation services should continue to be separately identified and reported using the HRG4 rehabilitation categories. Rehabilitation in this collection is used to describe:

- Patients who are admitted for discrete rehabilitation; or
- Patients who are treated on a discrete rehabilitation ward/unit; or
- Patients who are treated under specialty code 314.

511 The unit of activity that we require for reference costs 2010-11 is occupied bed day. The HRG4 2010-11 Reference Costs Grouper will output an unbundled HRG for discrete rehabilitation accompanied by a multiplier showing the days of rehabilitation within the FCE.

512 The rehabilitation length of stay needs to be removed from the APC Spell length of stay when reporting the 'core' Admitted Patient Care Spell HRG.

513 As per previous years, the reporting of rehabilitation services will be further broken down into 3 categories:

- 'Complex specialised' rehabilitation services (CSRS) (Level 1)
- 'Specialist Rehabilitation Services' (SRS) (Level 2)
- 'Non-specialist' Rehabilitation Services (NSRS)

514 To clarify, the unit of activity for Rehabilitation HRG4s and the unit of activity we would like reporting for reference costs are as follows:

Table 19: Reporting of Rehab

Hr Rehabilitation HRG4s	**Unit for Grouper Output**	**Unit Reference Costs reporting**	**Disaggregated further**
VC01Z to VC03Z	Attendance	Attendance	- Complex specialised' rehabilitation services (CSRS) (Level 1) - 'Specialist Rehabilitation Services' (SRS) (Level 2) - 'Non-specialist' Rehabilitation Services (NSRS)
VC01Z to VC42Z	'Days'	Bed Day	- Complex specialised' rehabilitation services (CSRS) (Level 1) - 'Specialist Rehabilitation Services' (SRS) (Level 2) - 'Non-specialist' Rehabilitation Services (NSRS)

515 Rehabilitation HRG4s will be generated by the recording of OPCS U50 – U54 codes. Organisations should refer to CFH coding guidance for further advice on when such OPCS codes should be recorded.

516 Where a patient is not admitted specifically to a rehabilitation ward/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 recorded under OPCS U50 – U54 codes and thus should not be reported as discrete rehabilitation.

Disaggregating Rehabilitation Services

517 Certain aspects of rehabilitative care are delivered by specialist providers within the NHS in England. Associated with the delivery of complex specialised and specialist rehabilitation are an expectation of increased resource usage and longer durations of Ordinary Admission (Elective or Non-Elective) 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.

518 Therefore, in support of the revised definitions of the national definition set in the Warner report, the 2010-11 Reference Costs requires that the NHS separately identify not only those complex specialised rehabilitations services, but also those that might be termed "specialist", in line with the definitions over the page:

'Complex specialised' rehabilitation services (CSRS) (Level 1)

519 The Department of Health's National Definition Set define specialised services, found:

www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Specialisedservicesdefinition/index.htm

520 This set includes 36 pre- defined specialised services, which are subject to different commissioning arrangements than other NHS services, as recently re-defined in the Warner report.

521 CSRS are high cost low volume services, already commissioned on a wide geographical basis (eg regional / supra-regional) to provide highly specialised services for people with complex needs.

522 CSRS that fall within this definition set and contain components relating to in-patient rehabilitation are:

- No 6: Specialised spinal services (all ages);
- No 7: Complex specialised rehabilitation for brain injury and complex disability (adult);
- No 9: Specialised burn care services (all ages); and
- No 31: Specialised pain management services (adult)

523 Under the recommendations of the Warner report, CSRS that fall within these definitions are being designated by the Specialised Commissioning Group, and will therefore be easily identifiable.

'Specialist Rehabilitation Services' (SRS) (Level 2)

524 A 'specialist rehabilitation service' is one that is not designated a level 1 (CSRS) service but has the following characteristics:

- 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;
- Carries a more complex caseload, as defined by agreed criteria;
- Meets the national standards for specialist rehabilitation laid by the appropriate Royal College and Specialist Societies eg the British Society of Rehabilitation Medicine (BSRM) for amputee musculoskeletal and neurological rehabilitation (including stroke and brain injury rehabilitation);
- Serves a recognised role in education, training and published research for development of specialist rehabilitation in the field.

525 Specialist societies such as the British Society of Rehabilitation Medicine 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, effectiveness and value for money in these Level 2 services.

'Non-specialist' Rehabilitation Services (NSRS)

526 Non-specialist is anything not specialist or complex specialised and is therefore identified be exception rather than by definition.

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527 Where Trusts cannot recognise themselves as either providers of specialist / complex specialised rehabilitation Services, in line with the above definitions, they should report as non-specialist.

Reporting and Costing Rehabilitation

528 An example of how the HRG4 2010-11 Reference Costs Grouper works and the reference cost output is shown below:

What happens to the patient?

Patient has Hip replacement (10 days)	Patient then has discrete rehabilitation as part of admission (20 days)
(Total Length of Stay for Spell = 30 days)	

What does the grouper output?

1 Hip replacement HRG generated (reported in the Elective workbook)	20 Unbundled rehabilitation HRGs generated (and reported in 'Services separately identified' workbook)

What days should be reported and where?

LOS = 10 days for 'Hip' HRG4 (and relevant working for Excess bed days if applicable)	Activity = 20 (days) for Rehabilitation HRG (reported in Services separately identified workbook)

529 If there are multiple types of rehabilitation delivery coded within a single episode, the HRG4 Reference Costs Grouper will output an unbundled rehabilitation delivery HRG per day per rehabilitation delivery type (as identified by the appropriate rehabilitation delivery OPCS code).

530 Organisations 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.

APC – Ordinary Admissions (Elective or Non-Elective), Day Case, Regular Day/Night)

531 Organisations using local data sources (and not the HRG4 Reference Costs Grouper) should use the appropriate coding guidance, as issued by NHS Connecting for Health, and the code to Group table, to identify which rehabilitation code (type) goes to which HRG4. The rehabilitation HRGs and the underlying source data, flags and lists used to derive these HRGs can be found at the link below: (click on HRG4 Definitions (Zip, 14.5MB) and select 'vc rehabilitation listing')

http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/healthcare-resource-groups-4-hrg4

Outpatients

532 Outpatient rehabilitation HRG4s (VC01Z – VC03Z) rely on OPCS4.5 coding, specifically, X601-X603 codes (please note that coding guidance also allows these to be used for Ordinary Admissions (Elective or Non-Elective). Where a rehabilitation assessment procedure is not recorded, then the HRG4 2010-11 Reference Costs Grouper will output a normal outpatient attendance (WF01/WF02). In the absence of having recorded OPCS4.5 codes, for rehabilitation, (in outpatients) please report rehabilitation outpatient attendances under TFC 314, in the appropriate place in the new collection structure.

533 It is not expected that rehabilitation HRG4s VC04Z to VC42Z (Rehabilitation Delivery HRGs) will be generated in an outpatient setting (as it is not generally coded). If you do generate delivery HRG4s in outpatients, then please ignore and report this activity under specialty 314 as an Outpatient. To allow DH to understand the mix of activity reported under Treatment Function Code 314, as Outpatients, please indicate the percentage (%) of activity and cost for outpatient (split by first and follow up) activity between the following 3 groups:

314 Outpatient Rehab Consultation
314 Outpatient Rehab Assessment
314 Outpatient Rehab Delivery

To report the above memorandum information, you should insert additional lines onto **Statement Z**.

534 Rehabilitation HRG4s (VC01Z – VC03Z) rely on OPCS4.5 coding, specifically, X601-X603 codes. These are assessment only not delivery, current coding guidance states that where a patient receives assessment and delivery during the same admission only one code is required for the delivery from U50-U54 as it is assumed that that assessment has already been carried out. A full list of Rehab OPCS 4.5 codes is available in **Annex F** of this document.

535 Where you report a discrete rehabilitation HRG4, you should **not** also report a 'normal' ('WF' prefixed) outpatient attendance.

Costing

536 Costs should be calculated and reported using full absorption costing principles.

537 Rehabilitation should only be separately identified where discrete rehabilitation has been carried out, such as when the TFC is 314. No attempt should be made to separately identify non-discrete rehabilitation costs during an Ordinary Admissions (Elective or Non-Elective) stay.

538 Increasingly, rehabilitation services are provided by community hospitals following transfer from an acute provider. Community hospitals should note the following when identifying and reporting such services for reference costs:

- For community hospitals that provide a rehabilitation service, this should be reported as rehabilitation on an occupied bed day basis, by HRG4 (see Table 19 above)

- 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.

- 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.

- 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.

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.

539 The types of patients that require rehabilitation vary considerably. These have been reflected in the new HRG4 categories. All of the Rehabiliation HRGs should be reported separately. In previous collections, some patients such as those with spinal injuries were already separately identified elsewhere in the collection. Spinal Rehabilitation HRGs have now been developed.

540 The costs/activity by HRG are not required to be split between children and adults.

541 Rehabilitation **should not** be used to describe:-

- The cost of activity beyond an HRG trimpoint for any ‘acute’ or non-specified HRG. This should still be reported as excess bed days.

Specialist Palliative Care

HRGs & Units of activity

542 All Specialist Palliative Care (SPC) services should be separately identified from other services and reported using HRG4 categories (the 2010-11 HRG4 Reference Costs Grouper should produce the SPC HRGs) and reported as per the following 4 categories:

- Ordinary Admissions (Elective or Non-Elective) (including support hospital teams);
- Day Case and Regular Day/Night;
- Outpatient; and
- Other

543 Please note that only discrete SPC activity and costs should be reported using the SPC HRG4 categories, for the reference costs collection. There are 10 SPC HRGs that can be used for reporting SPC activity and costs. Four of these refer to Ordinary Admission (Elective or Non-Elective) SPC (including 'same day'); four refer to SPC delivered in an outpatient setting and two refer to SPC support activity.

544 SPC HRG4s 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

545 This Care should usually be recorded using the Main Specialty Code 315, 950 or 960.

Ordinary Admissions (Elective or Non-Elective)

546 For Ordinary Admissions (Elective or Non-Elective) Specialist Palliative Care (not Same Day), SPC HRGs are reported on a bed day basis. At this stage, for information, this will be in addition to reporting the core HRG derived from other procedures recorded as part of the spell (further guidance to be issued at a later date), or derived from diagnosis where no procedures have been entered. Organisations will therefore be required to calculate and report the SPC number of bed days for the FCE activity.

547 The SPC episode needs to be removed from the APC record when reporting the 'core' Admitted Patient Care Spell HRG. This means that FCEs in TFC 315 should be removed prior to grouping the data.

548 If an Ordinary Admission (Elective or Non-Elective) 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 using one of the two SPC Support HRGs. (See table below for relevant HRG4 Codes). These HRGs should be reported in addition to reporting the core HRG derived from other procedures recorded as part of the spell (i.e. no core HRG exists when reporting on FCE basis), or derived from diagnosis where no procedures have been entered.

549 The table below describes the following Ordinary Admission (Elective or Non-Elective)) HRG4 SPC categories which should be reported for reference costs:

- Ordinary Admissions (Elective or Non-Elective) SD01A and SD01B
- Support Services SD03A and SD03B

Table 20: Ordinary Admission (Elective or Non-Elective) (excluding Day Cases) – Four HRGs

Ordinary Admissions (Elective or Non-Elective) (excluding Day Case)	
Unbundled SPC HRG	**Core HRG (if generated for FCE)**
Ordinary Admission (Elective or Non-Elective) Specialist Palliative Care SD01A or SD01B	Specific HRG derived from non-SPC procedures/ diagnosis
Hospital Specialist Palliative Care Support SD03A or SD03B	Specific HRG derived from non-SPC procedures/ diagnosis

Day Case and Regular Day/Night

550 Two HRGs have been created for Ordinary Admission (Elective or Non-Elective) Specialist Palliative Care, Same Day (SD02A and SD02B), to facilitate an Expert Working Group requirement. SPC HRGs for same day activity should be reported as 1 'bed day' in the collection file (the HRG4 Reference Cost Grouper will automatically add 1 bed day to your activity). This will be in addition to reporting the core HRG derived from other procedures recorded as part of the spell, or derived from diagnosis where no procedures have been entered.

551 The table below describes the following Ordinary Admission (Elective or Non-Elective) HRG4 SPC categories which should be reported for reference costs:

Table 21: Day Cases – Two HRGs

Day Case	
Unbundled SPC HRG	**Core HRG (if generated for FCE)**
Ordinary Admission (Elective or Non-Elective) Specialist Palliative Care Same Day SD02A or SD02B	Specific HRG derived from non-SPC procedures/ diagnosis

Outpatients

552 For non-admitted care, HRGs have been defined for both medical and non-medical specialist palliative care attendances. For non-admitted attendances, organisations should report an appropriate SPC HRG, and a core HRG derived from any significant non-SPC procedures recorded as part of the care record.

553 Where no significant non-SPC procedures are recorded, the HRG4 2010-11 Reference Costs Grouper will allocate a default core HRG non-admitted care attendance unless a specific entry of OPCS code X62.2 (Assessment by multi-professional team) or X62.3 (Assessment by multi-disciplinary team) has been recorded, in which case the core HRG allocated will be WF02Z (multi-disciplinary non-admitted care attendance).

554 **Where the patient attends for SPC only, and you report an outpatient SPC HRG4, you should not also report an outpatient attendance in Reference Costs.**

555 To clarify, the following table offers a guide to the type of unbundled SPC HRG that should be reported for each type of SPC activity, as well as providing an indication of the additional core HRG that could be generated.

Table 22: Outpatient - Four HRGs

Outpatients	
Unbundled SPC HRG	**DO NOT REPORT CORE HRG IF PATIENT ATTENDS FOR SPC ONLY**
Medical Specialist Palliative Care Attendance SD04A or SD04B	WF01A or WF02B Non-admitted care attendance
Non-Medical Specialist Palliative Care Attendance SD05A or SD05B	Specific HRG derived from non-SPC procedures where applicable, or a non-admitted care attendance

556 Organisations using local data sources should use the appropriate coding guidance, as issued by NHS Connecting for Health, the Code to Group table and the chapter specific documentation for Chapter SD (available on IC website), to identify the specific HRG4 that SPC activity and costs should be reported against.

Renal Dialysis

557 **Renal Dialysis services should be separately identified from other services and reported using HRG4 (the HRG4 Reference Costs Grouper should produce the Renal Dialysis HRGs). In order to support the change in HRGs and data flow (see below) for 2010-11 we have removed the categories (ordinary admission/Daycase etc). The renal worksheet will be updated to reflect the single setting for reporting renal HRGs.**

558 **The introduction of the new HRG4 subchapter LD Renal dialysis for chronic kidney disease and the deletion of the old subchapter LC means that dialysis for acute renal failure no longer generates and unbundled HRG. Therefore any costs associated with dialysis for acute renal failure should be included within the core HRG for that admission. Typically if no significant procedure have taken place the HRG generated will be one of the LA07 Acute Kidney Injury HRGs**

HRGs & Units of activity

559 **The NHS Information Centre has designed updated HRGs for renal dialysis based on data within the National Renal Dataset (NRD). These take account of the key drivers in cost and are split by age, dialysis type, complexity, and setting.**

560 **The 24 updated renal dialysis HRGs in the 2010-11 Reference Cost Grouper form a dedicated sub-chapter LD – Renal Dialysis (NRD). These HRGs will be built in to the 2010-11 Reference Costs Grouper replacing those within sub-chapter LC (from 2009/10 Reference Cost Grouper).**

561 **The chapter summary for subchapter LD will contain information about how the HRGs are generated from the NRD please see the Information Centre website.**

http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/costing

562 **Haemodialysis sessions i.e. each session of haemodialysis treatment received on a given day for each patient, continue to be used for reference costs purposes. The activity and costs for peritoneal dialysis should be reported on a per day basis. To assist NHS providers in planning their work to provide this mandatory collection and return, the working definition of each session/day for each patient across the financial year can be used.**

To clarify, the Unit of activity for Renal Dialysis HRG4s and the unit of activity we would like reporting for reference costs are as per Table below:

Reporting of Renal Dialysis

Setting	Renal Dialysis HRG type	Unit for Grouper Output	Unit Reference Costs reporting
Renal	**Renal (LD01A to LD12B)**	**Sessions (for haemodialysis) Days (for peritoneal dialysis)**	**Sessions (for haemodialysis) Days (for peritoneal dialysis)**

Haemodialysis

563 The HRGs below are to be used for reporting reference costs for haemodialysis undertaken within a hospital/satellite facility setting.

HRG code	HRG name
Hospital	
LD01A	**Hospital Haemodialysis/Filtration with access via haemodialysis catheter 19 years and over**
LD01B	**Hospital Haemodialysis/Filtration with access via haemodialysis catheter 18 years and under**
LD02A	**Hospital Haemodialysis/Filtration with access via arteriovenous fistula or graft 19 years and over**
LD02B	**Hospital Haemodialysis/Filtration with access via arteriovenous fistula or graft 18 years and under**
LD03A	**Hospital Haemodialysis/Filtration with access via haemodialysis catheter with blood borne virus 19 years and over**
LD03B	**Hospital Haemodialysis/Filtration with access via haemodialysis catheter with blood borne virus 18 years and under**
LD04A	**Hospital Haemodialysis/Filtration with access via arteriovenous fistula or graft with blood borne virus 19 years and over**
LD04B	**Hospital Haemodialysis/Filtration with access via arteriovenous fistula or graft with blood borne virus 18 years and under**
Satellite	
LD05A	**Satellite Haemodialysis/Filtration with access via haemodialysis catheter 19 years and over**
LD05B	**Satellite Haemodialysis/Filtration with access via haemodialysis catheter 18 years and under**
LD06A	**Satellite Haemodialysis/Filtration with access via arteriovenous fistula or graft 19 years and over**
LD06B	**Satellite Haemodialysis/Filtration with access via arteriovenous fistula or graft 18 years and under**
LD07A	**Satellite Haemodialysis/Filtration with access via haemodialysis catheter with blood borne virus 19 years and over**
LD07B	**Satellite Haemodialysis/Filtration with access via haemodialysis catheter with blood borne virus 18 years and under**
LD08A	**Satellite Haemodialysis/Filtration with access via arteriovenous fistula or graft with blood borne virus 19 years and over**
LD08B	**Satellite Haemodialysis/Filtration with access via arteriovenous fistula or graft with blood borne virus 18 years and under**

564 **These HRGs are designed to disaggregate renal haemodialysis by:**

- **Age – adult, child**
- **Location – hospital, satellite unit, home**
- **Access type – haemodialysis catheter, arteriovenous fistula**
- **With blood borne viruses/without blood borne viruses (e.g. Hepatitis B, Hepatitis C, and HIV).**

565 **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.**

566 **As the new HRGs are generated from the National Renal Dataset it should be easier than in previous years for Providers to identify all activity, which may not previously have been recorded on the hospital PAS system, in the APC or outpatient CDS but has been held locally.**

567 **However, there may be some difficulty in capturing per session activity for home dialysis patients. Therefore where not recorded on a per session basis the activity and costs for home haemodialysis should reflect the number of sessions prescribed.**

Home Haemodialysis

568 **For home haemodialysis, we propose to continue to collect and refine cost data with a view to incorporation within the mandatory scope of PbR in the future.**

The HRGs below are to be used for reporting reference costs for home haemodialysis.

HRG code	HRG name
LD09A	Home Haemodialysis/Filtration with access via haemodialysis catheter 19 years and over
LD09B	Home Haemodialysis/Filtration with access via haemodialysis catheter 18 years and under
LD10A	Home Haemodialysis/Filtration with access via arteriovenous fistula or graft 19 years and over
LD10B	Home Haemodialysis/Filtration with access via arteriovenous fistula or graft 18 years and under

Peritoneal Dialysis

569 **The activity and costs for peritoneal dialysis should be reported on a per day basis as described in the NRD and not on the basis of the number of bags or exchanges.**

The HRGs below are to be used for reporting reference costs for peritoneal dialysis.

HRG code	HRG name
LD11A	Continuous Ambulatory Peritoneal Dialysis 19 years and over
LD11B	Continuous Ambulatory Peritoneal Dialysis 18 years and under
LD12A	Automated Peritoneal Dialysis 19 years and over
LD12B	Automated Peritoneal Dialysis 18 years and under

Core HRG of LA08E

570 **For renal dialysis, when a patient receives dialysis and the activity is also recorded in the admitted patient care CDS the admission also generates a core HRG from sub-chapter LA.**

571 **For 2010-11 the associated core HRG for renal dialysis is LA08E: *Chronic kidney disease with length of stay 1 day or less associated with renal dialysis*.**

572 **As per previous years any activity recorded in the APC CDS that generates a core HRG of LA08E 'Chronic Kidney Disease with length of stay 1 day or less associated with Renal Dialysis', it is assumed that the admission is only for dialysis, therefore, please do not report the costs separately against LA08E.**

Costing

573 **For reference cost purposes there has been no change to the High Cost Drug treatments as follows, for 2010-11:**

- ***exclude* the costs of the Erythropoiesis Stimulating Agents (ESAs): Epoetin alpha, beta and zeta, and Darbetin alpha; and**

- ***exclude* the costs of Cinacalcet, Sevelamer and Lanthanum. We have added these to the list of excluded high cost drugs.**

574 In a number of cases, drugs related to associated conditions are required e.g. anaemia. These drug costs should be treated as any other cost of treatment and attributed at the point of delivery or as in outpatients, the point of commitment, unless separately identified in 2010-11.

575 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.

576 Similarly Renal Medicine admitted patient care costs should be mapped accordingly to Ordinary Admission (Elective or Non-Elective) cost pools and not to renal dialysis except where these costs are directly related to Ordinary Admission (Elective or Non-Elective) dialysis.

577 Care should be taken to ensure that all costs are appropriately allocated between haemodialysis and peritoneal dialysis. Costs should also include the revenue costs of buying and maintaining buildings and equipment, allocated appropriately between the different types of dialysis.

Exceptions

578 Please note that for all Outpatient Renal Dialysis activity, you should not report any separate 'WF' pre-fixed outpatient attendance information, for patients only attending for Renal Dialysis.

579 As already mentioned, the costs of any other defined high cost drugs HRGs must be excluded from dialysis reference costs and included on the high cost drugs return.

580 It is recognised that patient transport is a significant cost component of haemodialysis services but all Patient Transport Services (PTS – see below) (including taxis and private ambulances) must be excluded from renal dialysis submissions and included under the separate Trust PTS cost return.

Additional Information

581 The full range of staffing inputs should be allocated to all dialysis modalities including Medical and Nursing staff (including ESA management), Nutrition & Dietetic staff, Social Work, Pharmacy and Medical Engineering/Technical staff. Costing models must allocate these appropriately to PD therapies.

Patient Transport Services

582 **Non-emergency Patient Transport Services, known as PTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs.**

583 **For 2010-11 the intention is to exclude PTS from reference costs in order to reduce the burden on the NHS while work is carried out to improve the methodology behind the collection of quality PTS data. PTS data should therefore be reported as memorandum item under Statement Z (see below).**

584 **We propose use this interim measure while we to work with costing experts and development colleagues towards a new collection methodology for the 11-12 collection.**

585 **Where possible for reference costs purposes, activity should be reported on a patient attendance basis, but this can be used as a proxy for a patient journey/conveyed.**

586 **Most Patient Transport Services journeys are for outpatient appointments, hospital admissions and discharges of a routine nature, including transport to and from other healthcare facilities. Therefore to maintain this practice for reporting, where possible providers should make the best attempt to provide separate PTS quantums over the following 3 categories:**

- **APC - Ordinary Admission (Elective or Non-Elective), Day Case, Regular Day/Night**
- **Outpatient; and**
- **Other**

587 **Where, exceptionally, a friend or relative accompanies a patient to the hospital admission; any additional costs should be included as part of the patient "attendance" (journey). However, the escort is responsible for their own return transport and therefore we would expect no costs would be included.**

588 **NHS Ambulance Provider Trusts (and Mental Health Providers who are not applicable) continue to exclude PTS from their submission. NHS Direct (where appropriate) and air ambulance services continue to be excluded from the Reference Costs Return.**

589 **PCT providers should report the PTS the quantum of cost (and where possible the activity) commissioned from non-NHS providers (i.e. Independent) as well as PTS activity contracted out to Trusts.**

590 **Trusts should report the quantum of cost (and where possible the activity) they (and the Ambulance Trusts providing service to them) deliver as outlined above, to avoid double counting Trusts should not report costs and activity that PCTs have the responsibility for.**

591 Please note – any income received directly from the PCT for PTS activity should NOT be netted off the costs to ensure the reporting organisation reports the full associated costs of PTS.

Hospital Travel Cost Scheme

592 The Hospital Travel Cost Scheme (HTCS) provides financial assistance to NHS patients who do not have a medical need for Patient Transport Services, but who require assistance in meeting the cost of travel to and from their care. Patients on low incomes (eligibility is determined by benefits or allowances) are entitled to full or partial reimbursement for their actual travel expenses, if they travel by the cheapest means of transport available to them. HTCS is not available to visitors.

593 HTCS's need to be separately identified from all services and split by the following 3 categories:

- APC - Ordinary Admission (Elective or Non-Elective)), Day Case, Regular Day/Night
- Outpatient,
- Other

594 Activity should be reported on a patient attendance basis.

SECTION 9

SERVICES ACCESSED DIRECTLY

Direct Access Services referred to in this section are:

Area	Currency for reporting	Paras	Unify2 Reporting Worksheet
Diagnostic Services	Tests	597-604	Direct Access
Pathology Services	Tests and Requests	605-610	Direct Access

Introduction

595 Diagnostic support services such as Pathology, that are undertaken as part of Ordinary Admission (Elective or Non-Elective), day case, outpatient, Accident and Emergency care and Critical Care are included as part of the composite costs of these types of care, thereby maintaining the full absorption cost and matching principles that underpin the NHS approach to costing services.

596 There are however, numerous occasions when such diagnostic tests and services are carried out independently of these other types of care. **This activity is classified as 'Services Accessed Directly', thereby relating to all sources of referral for diagnostic tests and services outside the Ordinary Admission (Elective or Non-Elective), day case, outpatient, Accident and Emergency and other internal settings.**

Diagnostic Services

597 An ever-increasing range of services, including physiological tests, can be accessed directly by a patient, outside of Ordinary Admission (Elective or Non-Elective), day case, outpatient, Accident and Emergency and Critical Care settings.

598 In response to NHS feedback, the categories for clinical measurement tests have been revised, and extended considerably, to better reflect the type of tests now undertaken in this setting.

599 The list of clinical measurement tests that are to be reported in the 2010-11 collection will therefore be as follows: -

- 24 hour ECG / BP Monitoring
- Carpal Tunnel Screening
- Fluroscein Eye Screening
- ECG (12 lead)
- Echocardiogram
- Electrocardiogram
- Electromyography (EMG) / Electroencephalograph (EEG)
- Exercise Test (including Treadmill, etc.) / Stress Test
- Hydrogen and Urea Breath Tests
- Long-term Oxygen Therapy Test
- Nebuliser Assessment Test
- Spirometry Test and Broncho Dilator Response Test
- Other Test.

600 Please note the categories above cover patients who access treatment directly i.e. referred for tests and services outside Ordinary Admission (Elective or Non-Elective), Day Case, outpatient, A&E and Critical Care settings. Therefore, **the cost of outpatients clinics should not be included within this definition** (reported within the Outpatient section of the Reference Cost return).

601 Therefore, the intention is to differentiate between the method of referral, which for direct access patients are those **referred outside Ordinary Admission (Elective or Non-Elective), Day Case, outpatient, A&E and Critical Care setting**. NHS organisations should therefore be careful to avoid

double counting such activity taking place in one of these settings **(e.g. an Outpatient attendance for an echocardiogam)**.

602 Please note, in a change to previous years, simple echocardiograms are now recorded against the unbundled HRG RA60Z. Previously these were recorded under HRG EA46Z. In 2010-11, simple echocardiograms, grouping to RA60Z, should be treated in the same way as unbundled diagnostic imaging. I.e. the costs should be rebundled for admitted patient care and separately collected (unbundled) for outpatients, direct access and other.

603 Angiography and Diagnostic Endoscopy: Note that these should be reported under the appropriate procedure (outpatient) category. A separate category is no longer required.

604 Dietetics direct access is no longer required, superseded by the introduction of Dietetics into the outpatient collection.

Pathology Services

605 The 2010-11 collection requires cost and activity data to be submitted on a test basis, with the number of requests continuing to be required as a memorandum activity item on the collection files. Note that a unit cost per request is not required.

606 The category of phlebotomy within pathology services directly accessed by a patient was introduced largely as a result of requests from PCTs, who provide a blood collecting service, but have no access to laboratories in order to carry out pathology tests. This category should therefore be used for discrete phlebotomy services only. Non-discrete phlebotomy services should continue to be included as part of the composite cost of the relevant pathology specialty, as in previous years.

607 A robust definition of a pathology 'test' has remained elusive in reference costs to date. In 2010-11, the following definitions, developed by the National Pathology Alliance Benchmarking Review, should be used, wherever possible: [Note that the CFH contains the data standards definition of a request for pathology investigation]

- Clinical Biochemistry

  Requests: Work received from a single patient at one time usually, but not always, on a single specimen. A GP multi-request form for three departments e.g. Microbiology, Haematology and biochemistry, with a blood sample for investigations in all three departments, would be one request in each of the three departments.

  Tests: A result produced by an analytical process on a single specimen. Calculated results and comments describing a test or result should NOT be counted as tests.

- Haematology

  Requests: A request should be patient focused and related to specimens taken from one patient at one time whether they are dispatched to the department in one or a multiplicity of containers. A GP multi-request form for three departments e.g. Microbiology, Haematology and Biochemistry, with a blood sample for investigations in all three departments, would be one request in each of the three departments. (Samples taken from one patient at the same time may arrive in the laboratory at different times – they are still one request).

  Haematology Tests: A test is the output of either one analysis or a number of related analyses on a single analyser.

- Microbiology

  Requests: A request is one sample (which would normally receive one laboratory number.)

Tests: Work carried out as a single protocol of related work on one sample where reporting of only part of the work would be regarded as an incomplete result. However, to account for the additional work associated with clinically significant culture positive specimens (identification and/or antibiotic sensitivity procedures); these further procedures should score as one additional test per organism.

- Cellular Pathology

  Requests: A request should be patient focused and relate to specimen(s) taken from one patient at one time whether dispatched to the department in one or a multiplicity of containers and related to a single request form.

- Immunology

  Requests: Receipt of a single laboratory request form and accompanying appropriate specimen(s) drawn from an individual patient at one time, the whole of which having been submitted at the same time by a referring clinician.

  Test: A single analytical procedure.

608 The requirements for 2010-11 therefore comprise cost and activity calculated and reported on a test basis for:

- DAP823 Haematology
- DAP824 Histology / Histopathology
- DAP830 Immunology
- DAP831 Microbiology / Virology
- DAP832 Neuropathology
- DAP838 Cytology (should not include cervical screening programmes)
- DAP839 Phlebotomy
- DAP841 Biochemistry
- DAP842 Other

609 NHS feedback has indicated that there is an increased move towards '**combined labs**' using shared equipment, making it increasingly difficult to report Reference Cost activity. As per the 2009-10 collection there is currently no change, however an additional reporting category for 'Combined Labs' may be introduced in future collections and **organisations should look to collect this information from 1st April 2011 where appropriate.**

610 When producing costs on a full absorption costing basis, care should be taken to ensure that the entire costs of such services are included in calculations, namely:-

- That pathology costs include costs incurred in the transportation of samples.

SECTION 10

AUDIOLOGY SERVICES

Audiology Services covers the following areas:

Area	**Currency for reporting**	**Para(s)**	**Reporting Worksheet**
Assessment	Attendance	616-617	Audiology - Assessment
Delivery (Fitting)	Attendance	618-620	Audiology – Fitting
Delivery (Aids)	Total Number of Aids Issued	621-625	Audiology – Hearing Aids
Repairs	No of Repairs	626-627	Audiology – Repairs
Neonatal Screening	No. Screens	628-629	Audiology - Screening

Audiology Services

611 Services delivered within discrete Audiology Departments (not undertaken as part of ENT attendances) are currently identified separately and this will continue for the 2009-10 Reference Costs Collection.

612 This section of the Reference Cost return includes ongoing outpatient attendances and hearing tests conducted by audiologists and audiological technicians (i.e. following referral from ENT outpatient clinic). There is no requirement to report Services Accessed Directly separately.

613 As well as hearing tests, a range of other services are provided through audiology departments e.g. lip reading and relaxation classes, communication groups, environmental aids sessions, vestibular rehabilitation and OADS follow up. However, if services do not meet the requirements in the paragraph below, then they should be treated as **Excluded services**.

614 The range of services relating to audiology that form part of the mandatory collection are identified as follows:

- Assessment
- Delivery (including cost of fitting, aid)
- Repairs
- Neonatal Screening

615 *Not all clinics are held on central hospital premises, but the service is provided on a more localised basis. Where a NHS provider has contractual responsibility for the provision of the service, then these services need to be included in reference costs, regardless of location. The contractual costs involved in delivering these services should be included for comparative purposes.*

Assessment

616 It is expected that the activity that takes place as part of an hearing aid assessment will include the initial hearing test/assessment. The outcome of this assessment will then depend whether there is a requirement for a fitting of an hearing aid and a subsequent follow-up appointment.

617 The activity requirement for an hearing aid assessment is the **attendance**. The requirement will therefore be a unit cost per attendance and total number of attendances for each category.

Delivery

618 To better align with the non-mandatory pathway for direct access adult hearing services, the delivery aspect of the fitting of hearing aids it to be collected under the following headings;

- Cost of fitting of hearing aid

- Counselling and issue of aids for Tinnitus
- Cost of actual aid – Analogue Standard Aid
- Cost of actual aid – Analogue Superior Aids (including directional control)
- Cost of actual aid – Digital Aids
- 1st Follow up attendance

619 The activity requirement for the cost of fitting an hearing aid is the attendance. The requirement will therefore be a unit cost per attendance and total number of attendances.

620 To remain consistent with the non-mandatory pathway, we ask that organisations report only the cost and activity based on the first follow-up attendance only, Any deviation from the pathways and prices can be agreed locally, Patterns of subsequent 'follow-ups' vary considerably and can distort the cost.

621 Similarly, the activity requirement for counselling and the issue of aids for tinnitus would be a unit cost per attendance and total number of attendances.

622 The cost of the hearing aids issued will continue to be separately identified and reported in the appropriate section of the new collection structure. Costs of other repairs, moulds, tubes etc. should be included as an integral cost driver of the fitting services or hearing aid repair services.

623 It is recognised that new hearing aids are not issued solely to new patients and that new stronger aids may be required as a patient's hearing deteriorates, or a fault occurs which requires a new aid. It is **not** necessary to differentiate between hearing aids issued between these differing categories of patients.

624 For hearing aids issued in a given financial year, a unit cost per aid and the total number of aids issued is required for the following classifications of hearing aids:

- Analogue Standard Aids
- Analogue Superior Aids (including Directional control)
- Digital Aids

625 The Digital Hearing Aid Service is still included in the 2010-11 Reference Costs collection. The **full cost** of the digital hearing aid service, whether they be capitalised or not, (including any capital charges) should now be included in the collection.

For example, the purchase of digital hearing aids recorded as capital for funding will in effect mean that capital charges are payable and depreciation is built into the accounts. When performing local reconciliations, an adjustment may be needed to take account of this, taking out the depreciation charge and putting in the full costs. A note will need to be retained to cover that this adjustment has been made.

Repairs

626 The activity base for repair services will continue to be number of repairs, with a single repair service category of:

- Hearing Aid Repairs (including postal, patient attendance and "drop off").

627 No differentiation for the above services is made between adults and children.

Neonatal Screening

628 Neo-natal screening continues to form part of the mandatory collection requirements in 2010-11. This service is reported on the basis of number of screens and a corresponding unit cost.

629 *No separate costing guidance is provided on the costing of services resulting from these screening tests. If follow up treatments or interventions are required, this activity should be treated as inpatient or outpatient services, as appropriate, and standard costing guidelines for these services apply.*

Bone Anchored Hearing Aids

630 For information on Bone Anchored Hearing Aids see paragraphs 106-108(Section 2)

Audiology Summary

631 To summarise, Reference Cost submissions for discrete 'Audiology Departments' should reflect the following categories:

- Audiological Services return (i.e. delivery, normal & tinnitus; costs of hearing aids (including Digital); neonatal screening; aftercare); and
- Ongoing Assessments and follow-ups carried out in the Audiology Department following original referrals from ENT outpatient appointment (where no activity has taken place).
- Audiology activity done in a discrete Audiology Department via referrals from GPs

632 **Audiology** services **must not** be **reported separately** when:

- The first referral to the Audiology Department takes place in ENT outpatient clinic (include costs in ENT Outpatient attendance) i.e. the activity might not take place – referral only;
- Audiology activity is done as part of ENT outpatient appointments - include costs within the ENT Outpatient costs i.e. activity might take place in subsequent appointment following referral;;
- Audiology activity is done via referrals from GPs but not taking place in discrete Audiology Department – report as Audiology Outpatient clinics under specialty 254, 310 or 840 on the Outpatient return.
- Bone Anchored Hearing Aids should be reported in the Admitted Patient Care return (See Section 2)

SECTION 11

OBSTETRICS AND MATERNITY SERVICES

Obstetrics and Maternity Services in this section refer to:

Area	**Currency for reporting**	**Paras**	**Unify2 Reporting Worksheet**
Non-Elective – Obstetrics Non-Elective - Midwife Episodes	LOS (S or L), TFC 501 & HRG4 LOS (S or L),TFC 560 & HRG4	634-648	Ordinary Admission (Elective or Non-Elective) Ordinary Admission (Elective or Non-Elective)
Day Case – Obstetrics Day Case - Midwife Episodes	TFC 501 & HRG4 TFC 560 & HRG4	634-648	Day Case Day Case
Community Midwife Services Community Midwife Visits	HRG4 Visits	643-644	Community – Midwifery Community - Visits
Maternity OPs – Obstetrics Maternity OPs - Midwife Episodes	CL, TFC 501 and HRG4 NCL, TFC 560 and HRG4	645-648	OP Attendances OP Attendances

Well / Healthy Babies

633 Please note, the HRG4 PB03Z 'Healthy Baby' should be **excluded from the reference costs return,** as this is the equivalent of 'Well Babies,' which continue to be excluded from the collection (see section 16). For reporting purposes, the HRG will not be available in the collection system for 2010-11.

Non-Elective

634 These services should be reported as Non-Elective activity under the Treatment Function Headings shown in paragraph 530 below. Please be aware that obstetric activity should not take place in an elective setting so any activity reported at this level should be questioned.

635 All Non-Elective activity forms part of the collection for the following:-

501 Obstetrics
560 Midwife Episodes

636 For obstetrics, where a patient passes between consultants as part of a single obstetrics episode the whole costs should continue to be brought together and recorded as one HRG4. The activity recorded is the delivery episode in the majority of cases. The number of episodes should not be artificially inflated by the recording of well babies. Where a baby is discharged at the same time as the mother, this is counted as one delivery episode for reference costs purposes (i.e. well babies are not the patient, rather the patient is the mother with a delivery episode).

637 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) and who need additional care and treatment e.g. special care will generate activity in these areas and this should be counted separately and recorded as Critical Care activity in the appropriate place in the new collection structure, against the relevant services. NB In line with Data Dictionary definitions it is not necessary for a baby to actually be physically transferred to a Critical Care unit for the treatment to be coded as "not well".

<u>The Replacement of "N12" – Ante Natal Admission</u>

638 The introduction of HRG4 for reimbursement has meant that HRG N12 (ante natal admission not related to a delivery event) has been replaced by HRGs NZ04 to NZ09.

639 Please note, HRG4 categories NZ04A – NZ06Z are of a short-stay nature and can therefore only be costed with an LOS of zero. However, the expected differentiation in reported costs for these HRGs has not occurred, with comparatively high costs reported for the simpler HRGs given their likely duration.

640 Therefore, Reference Cost Leads should be mindful that when calculating unit cost for HRGs NZ04 to NZ09, other (more complex) cost drivers often should take precedent over LOS, such as:

- Scan type
- Any observations / investigations etc

For example, we would expect that a 25 year old patient attending for a routinely mid-trimester for 30 minute scan appointment would have a different resource use than that of a patient attending with false labour who receives 4 hours of observation. The former would map to NZ05A Clinical contact with investigation (ante- or post-natal) 19 years and over, the latter to NZ04A Clinical contact for observation (ante- or post-natal) 19 years and over.

641 In reference costs 2009-10 a number of new HRGs were introduced for obstetric deliveries. For 2010-11 organisations should continue to report using these HRGs, which differentiate between delivery requiring epidural, induction and post-partum surgical intervention. This is to better reflect the costs associated with different types of delivery. The caesarean section HRGs differentiate between planned, unplanned and complex caesarean sections. See Table below:

HRG	Label
NZ11A	Normal Delivery with CC
NZ11B	Normal Delivery without CC
NZ11C	Normal Delivery with Epidural with CC
NZ11D	Normal Delivery with Epidural without CC
NZ11E	Normal Delivery with Induction with CC
NZ11F	Normal Delivery with Induction without CC
NZ11G	Normal Delivery with Post-partum Surgical Intervention
NZ12A	Assisted Delivery with CC
NZ12B	Assisted Delivery without CC
NZ12C	Assisted Delivery with Epidural with CC
NZ12D	Assisted Delivery with Epidural without CC
NZ12E	Assisted Delivery with Induction with CC
NZ12F	Assisted Delivery with Induction without CC
NZ12G	Assisted Delivery with Post-partum Surgical Intervention
NZ13Z	Planned Lower Uterine Caesarean Section
NZ14Z	Emergency or Upper Uterine Caesarean Section
NZ15Z	Caesarean Section with Eclampsia, Pre-eclampsia or Placenta Praevia

642 Routine HIV/Aids tests are offered to mothers and these costs should be treated as an indirect cost to the relevant service area. Such tests are usually carried out via obstetrics outpatients/ante natal clinics. The costs should be reported in the relevant section of the new collection structure..

Community Services

643 Community (**home**) deliveries also form part of the collection, and these continue to be shown separately from hospital based deliveries. Providers are encouraged to identify all the costs of home deliveries e.g. the cost of having an obstetric unit to provide medical cover if necessary. Non-hospital deliveries form part of the mandatory collection, and steps should be taken to ensure that this information is routinely collected and accessible within comprehensive midwifery records and systems.

644 Ante-natal and post-natal visits **in the home** also form part of the collection. Ante-natal and post-natal visits should be recorded, costed and reported separately (as community services), as in previous years.

Maternity Outpatients

645 The 'pre-booked' element of outpatients definition was removed in reference costs 2008-09, bringing the definition in line with the NHS Connecting for Health (CFH) Data Dictionary. Please see further details in section 3 of this guidance.

646 As a general guide, Obstetric Care (specialty 501) is usually provided by consultants, whereas ante-natal care is often directly provided by midwives (specialty 560). In 2010-11,this activity/cost data should all be reported as Outpatient Services in the new collection structure and be split by Face to Face/Non Face to Face and by 'Consultant Led/No Consultant Led' – Consultant Led activity should be grouped to **TFC 501**, Non-Consultant Led activity to **560.**

647 These specifically include midwifery ante-natal care undertaken by the NHS provider in GP surgeries, which should be included as part of ante-natal outpatients. The setting of an Outpatient Clinic is no longer relevant, so long as it fits the Outpatient Definition as per NHS Connecting for Health.

648 **As per previous years**, and for the purposes of tariff development, the collection of ante-natal ultrasound data should be reported separately (if possible) to obstetrics outpatients, as follows:

- Under the relevant NZ HRG code
- Using the new artificial 'Treatment Function Code' 501OU (created for reporting purposes)

SECTION 12

PARAMEDIC SERVICES PROVIDED BY NHS AMBULANCE SERVICE PROVIDERS

Paramedic Services

Area	Currency for reporting	Paras	Unify2 Reporting Worksheet
Paramedic	Incidents, Responses, Patient Journeys, Calls	649-683	Paramedic

649 These services were introduced into Reference Costs in 2003 and should be reported by the NHS Ambulance Trusts. The activity and costs included in the collection relate to **incidents** for Emergency (999) calls, Urgent and Emergency High dependency transfers. **Note that the activity data should reflect the activity levels per the annual KA34 ORCON return to the Department of Health;** Incidents should therefore be less than the number of calls shown in line 01 of the KA34 – see Annexes. Response data will continue to form part of the Reference Costs collection from an activity requirement perspective only.

Please Note – The Department are working with the Ambulance PbR Group to introduce a collection based around the incoming currencies. Collection of data for reference costs 2010-11 will remain as per previous years, however organisations may be asked to submit data for the new currencies as memorandum information where possible. This approach will be confirmed and communicated in 2011.

650 Allowable reconciling items to KA34 ORCON Return:

- Telephone advice
- Out of Hours Service
- Routine ECP & PP assessments
- Routine transport
- Unclassified/uncoded

651 As in previous years' collections, the basis of activity for Paramedic Services provided by Ambulance NHS Trust is **incidents**, although the number of responses is required as a memorandum item. Incidents differ from calls, responses and patient journeys. The collection is based on a full year's activity and costs as for other NHS services and will be reported on the same timescales as detailed throughout this guidance.

652 The following should be noted for 'Incidents':

- An incident is an event that results in one or more calls being made to the emergency ambulance service provider.
- For example, five calls re: the same event equals one incident.
- An incident may result in a response by an ambulance resource, e.g. an ambulance, rapid response vehicle, motorbike, etc., or may result in a transfer to other NHS Services, e.g. NHS Direct, etc.
- The number of incidents will be equal to or less than the number of calls received, but may be greater or less than the number of responses.
- For example, the number of incidents will be more than the number of responses where an incident does not result in a response.
- The number of incidents will be less than the number of responses where more than one type of response is issued.

653 With regard to 'Major Incidents', where resources are solely dedicated to providing cover for major incidents, these should continue to be reported separately in the Reference Costs collection, using the appropriate category. Where resources are not dedicated to major incidents (Any occurrence which presents a serious threat to the health of the community, disruption to the service, or causes [or is likely to cause] such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance services or health authorities) , they should be included in the composite Category A, B and C return, as appropriate.

654 Similarly, for responses:

- Activity relates to the number of responses activated, **including abortive responses**.
- Where more than one type of response is issued, e.g. Rapid Response and Ambulance, these will count as two responses.
- Responses include those by Rapid Response Vehicles, Fast Response Vehicles, Paramedic Response Units, Ambulances, Motorbikes, Pushbikes, etc.
- The exception to the above treatment relates to potential or actual major incidents. In these cases, the 'standard' response may be the dispatch of a pre-determined number of personnel and vehicles. For these incidents only, this counts as a single response. If subsequently, additional crews, vehicles, etc., are required, this should be counted as a second, third, etc. response as required.
- Some ambulance service providers may use the term 'activation' for this type of activity.

655 The analysis will cover:

- Incidents of Category A (Red) calls, defined as 'Patients who are or maybe life threatened and will benefit from a timely clinical intervention', analysed and costed over 32 codes;
- Incidents of Category B (Amber) calls, defined as 'Patients who require urgent face to face clinical attention but are not immediately life threatened', analysed and costed over 32 codes;
- Incidents of Category C (Green) calls, defined as 'Patients who do not require an immediate or urgent response by blue light and may be suitable for alternative pathways of care', analysed and costed over 23 codes;
- Urgents and Emergency Transfers combined.
- Other 999 calls analysed and costed across 4 categories;

656 As in previous years, cost and activity data for Category B and Category C incidents are required to be reported separately.

657 Certain classifications are no longer required for Category C. The categories to be used for the analysis of calls have been amended and are shown in **Annex G** of this document.

658 No further subdivision of the combined urgents and emergency transfers category will be included at this point. The collection files will therefore only include one further category for these types of transfer.

659 The categories to be used in the analysis of other 999 calls are:

- Major incidents (including airports);
- Out of Hours service (where NHS ambulance provider has taken over the responsibility of providing this service from GPs, and where the service is commissioned by PCTs);
- Transferred for telephone advice;
- Unclassified / uncoded;
- Other.

660 Patient Transport Services (PTS) provided by NHS Ambulance Trusts, NHS Direct (where appropriate) and air ambulance services continue to be excluded from the Reference Costs return. These are already reported by the **Trust** for whom the service is provided (see section 8).

661 All of Helicopter Emergency Medical Services (HEMS) activity and costs continue to be excluded from the reference costs collection.

662 Note that the costs of activity provided by Emergency Care Practitioners [ECPs] should form part of the composite costs of the Reference Costs submission, in line with the principles of total absorption costing. **Statement Z** will require costs and activity [WTEs] of ECPs included as part of the submission data.

663 Although changes have been made to the original collection requirements that were introduced in 2003, the process of monitoring and reviewing of the collection requirements, as with all costs and classifications, will continue in future years.

In terms of additional benchmarking opportunities, and whilst incidents remain the agreed reporting requirement for unit costs, activity data for journeys and calls, as well as responses continue to be included in all relevant services areas. Definitions and activity reported for calls and journeys should be those used for the **KA34 ORCON** return to the Department of Health.

Service Costing

664 *The costing of these services should fully comply with the principles and concepts outlined in this guidance.*

665 *In costing these services attention should be paid to the clear and transparent allocation of direct costs to the relevant services. Wherever possible costs should be directly attributed to services. Levels of indirect and overhead costs should be apportioned with due attention to their relationship to service provision. The approach and resulting figures should be robust and stand the test of audit scrutiny.*

666 *Wherever possible, the overall approach to reference costs is based on services relating to presenting and/or final diagnosis. In this respect the allocating of costs and activity for these services has parallels with those of Accident and Emergency (A&E) services.*

667 *Like A&E services, emergency ambulance services carry an element of costs associated with a 'state of readiness'. They are therefore staffed and equipped to deal with 'expected' levels of throughput. These costs should be included in the costing of these services to ensure the principle of full absorption costing is met.*

668 *As a first step in undertaking the costing analysis, it is important to apply the matching principle to ensure the expenditure relates solely to the services to which it is attributed.*

669 *Similarly expenditure should be net of any Category C income including commercial income. Trading activities do not form part of this analysis, although maintenance costs associated with vehicle repairs should be attributed to the relevant vehicles in line with current accounting practice.*

670 *Other forms of commercial income should also be netted off from the cost base. For example where an emergency service is provided on standby at football matches, the commercial income received should be netted off emergency service provision. In activity terms any resulting emergency activity generated should be deducted from the total emergency responses.*

671 *Following on from this, clear control totals need to be established for the different elements of service provision as applicable*

- *Patient Transport Service (PTS)*
- *NHS Direct*
- *Out of Hours Services*

- *Emergency Service*
- *Urgent / Emergency Transfers*

672 *The first two elements are not currently part of the reference costs collection.*

673 *The resulting costing analysis is dependent on the degree of analysis undertaken in the above stage. If as part of the above stage, staff grades, vehicles, etc. are directly attributed to these service classifications, the degree of manual intervention required is minimised.*

674 *When attributing or allocating staff and vehicle costs, it should be remembered that the cost of PTS vehicles/crews used to support emergency services in given situations should be included in the costs for these services, and not under patient transport.*

675 *The full quantum of costs for all services should reconcile to expenditure within the final accounts, subject to the above amendments regarding income. This acts as a check that all costs are included in the return which is based on actual costs in a given year.*

676 *The actual costs figure will not reconcile to contractual income. This is not of concern for the production of reference costs which are actual, retrospective costs. Any cross-subsidisation of work should be avoided however particularly in the light of financial flows reforms and the development of a national tariff.*

677 *To assist with the detailed costing of these services a minimum classification of costs for use by Ambulance service providers is attached at Appendix 4 of this Manual. This differs in some areas from the standard classification for NHS providers and from local analysis which has been used in the past.*

678 *Whilst this classification states the minimum national standard there are restrictions on the ability to adapt these locally. Movement is allowed from overhead to indirect classification and from indirect to direct. No movement or reclassification in the opposite direction is permissible. If for example an organisation sought to treat a direct cost as an indirect cost this is contrary to the mandatory regulations within this Manual and is deemed to be non-compliance as required by the signed Statement of Compliance.*

679 *In developing this Manual, particular concerns have been raised in relation to waiting/down time. This has parallels with the theatres and A&E Departments. The cost associated with these time periods should be included to comply with the full absorption cost principle. These contribute to the 'state of readiness' which is a feature of the service delivery.*

680 *In costing these services, it is important that all costs are included in the relevant cost pools. These may be an amalgam of different cost centres, and may cut across cost centres. All staff and associated costs need to be attributed and allocated to the activity as defined above.*

681 *To allow consistency in the costing process, downtime should not be costed as a separate element. In calculating a charge for different staff categories, therefore, the costs should be fully inclusive of all staff time, including oncosts, and this should be seen as a direct actual cost to the service activity. This will ensure that all costs from the various staff costing pools are fully recovered.*

682 *It is important that the reconciliation statements are completed in order to enable the Central Department team to check that NHS providers are adhering to the full absorption costing principles detailed in this Manual. It should be noted that these statements form part of the formal return.*

683 *As with the costing of all NHS services, the providers of these services should ensure compliance with all relevant parts of this mandatory Manual and not just the specific elements in this Chapter.*

SECTION 13

MENTAL HEALTH SERVICES (PROVIDERS OF SPECIALIST MENTAL HEALTH SERVICES ONLY)

684 **Please note that at the time of publication of the 2010-11 final reference costs guidance, a decision has not yet been reached as to the method of collection for mental health data in the 2010-11 reference costs exercise. There are still ongoing discussions as to the most appropriate basis upon which to collect the data. It is expected that there will be a collection of mental health data on a cluster basis in 2011, in order to support the expansion of Mental Health PbR. The decision outstanding is whether cluster data will replace the existing mental health currencies for reference costs 2010-11 or will be a separate parallel collection.**

685 **As such the mental health chapter of this guidance document currently remains largely unchanged from that issued in the 2009-10 collection guidance. Organisations should however now be working towards, and be prepared to submit some 2010-11 cost data on a cluster basis in 2011. Further communications including appropriate guidance will follow once a decision has been made.**

For 2010-11, Mental Health Services in this section refers to:

Area	**Currency for reporting**	**Paras**	**Unify2 Reporting Worksheet**
Ordinary Admissions (Elective or Non-Elective)	Occupied Bed Days	690-696	MH – Occupied Bed Days
Secure Units	Occupied Bed Days	697-700	MH – Occupied Bed Days
Ordinary Admissions (Elective or Non-Elective) - Specialist Services	Occupied Bed Days	701-702	MH – Occupied Bed Days
Day Care Facilities – Regular Attendances	Patient Days, Adult/Child/Elderly	739-747	MH – Patient Days
Consultant Non-Specialist Services (Outpatient Setting)	Attendances, DNAs, Face-to-Face / Non, First Attendance, Follow Up Attendance	703-715	MH – OP Attendances
Consultant Services (Outpatient Setting) – Specialist Services	Attendances, DNAs, Face-to-Face / Non, First Attendance, Follow Up Attendance	716-719	MH – OP Attendances
Consultant Non-Specialist Services (Community Setting)	Contacts, Face-to-Face / Non, First Attendance, Follow Up Attendance	703-715	MH - Community
Consultant Services (Community Setting) – Specialist Services	Contacts, Face-to-Face / Non, First Attendance, Follow Up Attendance	716-719	MH - Community
Community Mental Health Teams (CMHTS)	Contacts, Face-to-Face / Non	720-729	MH - Community
Mental Health Specialist Teams (MHSTS)	Contacts, Face-to-Face / Non, Adult/Child/Elderly	730-738	MH – Specialist Teams

686 As Mental Health Trusts are not yet being part of the Payment by Results process, they do not work at either specialty or HRG4 level, but in discrete service units broken down initially into Ordinary Admissions (Elective or Non-Elective), Outpatient, Community, Day, Specialist Teams and Excluded Services. Detailed notes about these service units follow below.

687 Please note HRG4 Chapter WD (Mental Health HRGs) should be used by non-specialist Mental Health providers only. More details about the Mental Health HRG4 can be found in the 'HRG4 Chapter Summaries' on the IC website (link below).

http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/healthcare-resource-groups-4-hrg4

688 The process for Mental Health Providers remain based in Absorption Costing methodologies whereby the total quantum of costs is calculated, broken down to the lowest required level before being matched to the appropriate activity information to allow a rate per unit of activity to be calculated.

689 **Note that where a patient receives treatments as if a child, adult or elderly patient, costs and activity of such treatment should be reported in the relevant category, irrespective of whether the patient is technically classed as a child, an adult, or an elderly patient.**

Ordinary Admission (Elective or Non-Elective) Services (i.e. Inpatients)

690 Mental Health providers should provide data against Mental Health codes within the collection workbooks to report their Ordinary Admission (Elective or Non-Elective) activity (these are not expected to change from previous years).

691 The 2000-01 collection introduced Ordinary Admission (Elective or Non-Elective) stays (for MH Providers) on an occupied bed day basis, rather than on a bed night basis. A particular feature of admitted Ordinary Admission (Elective or Non-Elective) care for Mental Health Services is the use of 'leave', sometimes referred to as 'home leave', in the treatment of patients. Some admitted Ordinary Admissions (Elective or Non-Elective) are 'sent on leave' to return at a future date. They are not discharged, however their beds are used for other admitted patients. To include these 'sent on leave' days as activity in Reference Costs for these services serves to increase occupancy levels to more than 100%, and effectively dilute the cost per occupied bed day.

692 In a clarification of the counting treatment for patients on home leave, therefore, organisations should ensure that **the reported total number of occupied bed days does not include any element of 'leave' day activity,** unless a bed is retained solely for use by the patient on leave, and is not filled in their absence. This will ensure that the activity reported as part of Reference Costs for Mental Health Ordinary Admissions (Elective or Non-Elective) services will never exceed 100% occupancy, and that reported total unit costs per occupied bed day will reflect the actual costs incurred by an NHS provider per occupied bed day.

693 Some activity information systems do not allow the identification of beds retained solely for use by the patient on leave. In such circumstances, where the occupancy for a site specialty exceeds 100% of available bed days in a month, the OBDs for that site specialty in that month should be reported only as 100% of available beddays in the Reference Cost OBDs for that month i.e. the 100% maximum occupancy relates to each site specialty each month. It should be noted, therefore, that in such cases each month needs to be calculated separately.

694 When a client is temporarily transferred from the specialist MH provider to an acute trust e.g. medical ward then treat the beddays as with 'on leave' i.e. only counted if bed retained solely for the use of the patient (with 100% maximum occupancy rule).

695 Ordinary Admission (Elective or Non-Elective) services are further sub-divided based on the specialty of the consultant responsible for the clients care, into distinct bandings for the care of adults, children and the elderly based upon where a patient receives treatment i.e. an adult suffering from dementia cared for by Elderly specialists would be classed as 'Elderly'. In addition, the adult category is split between Acute, Intensive and Rehabilitative care.

696 This is consistent with the approach adopted by the National Service Framework for mental health services but providers should also be careful not to overstate true bed day activity when sub-dividing this activity.

Ordinary Admission (Elective or Non-Elective) Services i.e. Inpatient – Secure Units

697 Secure units have been included in reference costs since 2001/02. For consistency, the unit cost and activity information is based on occupied bed day data. As with other elements of mental health services, the service mapping definitions should continue to be used for:-

- Local Psychiatric Intensive Care Units
- Low Secure Services
- Medium Secure Services
- High Dependency Secure Provision
- Maximum Secure Units (to be used by three designated units only; Broadmoor, Rampton and Ashworth).
- Child & Adolescent Low Secure Services [four designated units only – see para. tbc]
- Child & Adolescent Medium Secure Services [four designated units only – see para. tbc]
- Child & Adolescent High Secure Services [four designated units only – see para. tbc]

698 Based on feedback from NHS providers of High and Maximum Secure Unit Services, refinements were included for this group of specialist units in 2002/03. These refinements continue to form part of the 2010-11 collection. Activity is thus required on an occupied bed day basis, split over five clinical groups:

- Women's Services
- Mental Health/Psychosis
- Learning Disabilities
- Personality Disorder &
- Dangerous and Severe Personality Disorder [for Maximum Secure Units only].

699 Please note that Maximum Secure Units are only required to provide DSPD information if their units are fully operational. If your service is not yet operational, you may continue to exclude these services from your collection.

700 The four designated units that are required to submit data for Child and Adolescent Secure Services are:

I) Newcastle,
II) Birmingham
III) Salford
IV) South London & Maudsley

Ordinary Admission (Elective or Non-Elective) Services i.e. Inpatient – Specialist Services

701 In addition, the specialist services introduced in 2001/02, are retained in 2010-11. Unit cost and activity data is based on occupied bed days.

- Autistic Spectrum Disorder
- Eating Disorder Services (sub-divided between services for children and adults)
- Mother and Baby Units (the service definition included in the service mapping exercise should be applied here).

702 The inclusion of these services brings the majority of costs for mental health Ordinary Admission (Elective or Non-Elective) services into the collection. Work is still ongoing to develop costing for psychological therapy services, day unit / hospital services, and support services such as self-help and advocacy schemes.

Mental Health Non-Specialist Consultant Services (Outpatient and Community Setting)

703 Where consultants have a clinical caseload within a **specialist team** e.g. Crisis, Assertive Outreach, Early Intervention, the consultant costs & activity should be reported within those of the **specialist team** (see Mental Health Specialist Teams, paragraph 730 onwards).

The 2010-11 collection requires that where consultants do **not** have a clinical caseload within a **specialist team**, their activity & costs should be reported as outpatient or community setting.

704 The key to determining whether activity should be classified as outpatient or community setting is set out below:

- If the appointment is booked into a clinic list for a specific clinic session, including clinics in a residential home (i.e. where a consultant sees more than one patient in that clinic & location), then classify as outpatient setting (under consultant led or non-consultant led heading as appropriate);

- Otherwise it should be reported using the community setting category e.g. home visit (and domiciliary visit), i.e. an appointment in a client's home, including a visit to a single client in a residential home.

705 Consultant Services (Outpatients and Community Setting) need to identify the activity and costs associated with non-face to face activity. Please note that 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. A non face to face contact should replace the need for an outpatient face to face attendance. Telephone contacts solely to inform patients of results are excluded. 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.

706 In addition, these services for adults continue to be sub-divided further, to provide separate activity and cost data for drug and alcohol services and other types of outpatients. The split between drug and alcohol and other types of outpatients will be retained for mental health services provided to children. Costs and activity relating to Methadone Swallow and Depot Injection Clinics continue to be **excluded** from the Reference Costs collection exercise in 2010-11.

707 Primary consultations/initial assessments BEFORE the patient ATTENDS for a traditional first appointment (including Mental Health services such as CAMHS & CMHTs) 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.

708 The collection for first attendance outpatient mental health services will therefore resemble the following (split Face to Face and non-Face to Face):

Table 26: Mental Health Services collection

Code	Narrative	Unit cost per First Attendance £	Total No. of First Attendances	Total No. of DNAs First Attendances
MHOPFAA1	Adult: Drug & Alcohol Services			
MHOPFAA2	Adult: Other Services			
MHOPFAC1	Child: Drug & Alcohol Services			
MHOPFAC2	Child: Other Services			
MHOPFAE1	Elderly Services			

709 Note that the above information will also be required for mental health outpatient follow-up attendance data. **DNA memorandum data is required for such mental health activity in Statement Z.**

710 **Domiciliary Visits** 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 purposes is between:

a.) costs of seeing a client in a clinic, and

b.) costs of seeing a client at home (as per paragraph 586 above)

The costs of a) are categorised as Outpatient, and the costs of b) should comprise **both** consultant Home Visits and consultant Domiciliary Visits. Therefore, the separate Domiciliary Visit category becomes obsolete and data is not separately reported, instead included in the general collection structure.

711 Due to the anticipated volume of data involved, and the paucity of automated recording systems for the majority of community-based mental health services, it is acceptable that organisations use appropriate and reflective sample data to ascertain annual activity for Mental Health Community-based services. There is no minimum sample time stipulated within Reference Costs; rather, the sample should be reflective of annual activity undertaken within a service area. Where this is not feasible, organisations may use informed clinical estimates if necessary, although it is advisable to retain hard copy evidence of the data source.

'Did Not Attends'

712 Due to the particular nature of mental health services, DNAs (did not attends) utilise considerable mental health resources, therefore outpatient activity for mental health services requires DNA activity to be identified and reported separately as a memorandum item only in the Unify2 collection file. Please ensure that DNA activity is NOT evaluated in any way and it **must not be included** in the main activity for outpatients/community – to do so would dilute the reported unit costs.

713 There is no requirement to submit unit cost data for DNAs. This means that:

- The total cost of a specific outpatient service, calculated using total absorption costing methodology should be identified, for each category of collection, for each of first and follow up outpatient attendances in mental health.
- Activity for the total number of face to face attendances for each of first and follow up attendances should be identified. Also activity for the total number of non-face to face attendances for each of first and follow up attendances.
- Unit cost for each type of attendance should be calculated by dividing total cost by the total number of face to face attendances for each of first and follow up attendances. The process should be repeated for non-face to face attendances.
- In addition, total number of DNAs for each of first and follow up attendances should be reported as a memorandum item. This activity must not be included in the total face to face or non-face to face activity reported, nor in the calculation of the unit cost per face to face or non-face to face attendance.

Outpatient DNAs

714 Memorandum DNA activity is reported within all Outpatients and Specialist Outpatient categories for Face to Face and Non Face to Face categories as both First and Follow up.

Community DNAs

715 Community activity is reported in the same way except that Memorandum DNA activity for community activity is entered in **Statement Z** only, not within the relevant collection file.

Mental Health Consultant Specialist Services (Outpatient and Community Setting)

716 The 2010-11 collection will require the following mental health consultant services to be reported as outpatient or community setting:

- Autistic Spectrum Disorder
- Eating Disorder Services (sub-divided between services for children and adults)
- Mother and Baby Units (the service definition included in the service mapping exercise should be applied here).

717 The community services collection for Specialist Services follow up contacts will resemble the following (split Face to Face and non-Face to Face):

Table 27: Mental Health Specialist Services collection

Code	Narrative	Unit cost per Community-based Follow Up Contact £	Total No. of Community-based Follow Up Contacts
MHCYSSFUASD	Autistic Spectrum Disorder		
MHCYSSFUEDA	Eating Disorder Services: Adult		
MHCYSSFUEDC	Eating Disorder Services: Child		
MHCYSSFUMBU	Mother & Baby Units		

718 Note that the above information will also be required for community-based first contact data.

719 Due to the anticipated volume of data involved, and the scarcity of automated recording systems for the majority of community-based mental health services, it is acceptable that organisations use appropriate and reflective sample data to ascertain annual activity for Mental Health Community-based Specialist services. There is no minimum sample time stipulated within Reference Costs; rather, the sample should be reflective of annual activity undertaken within a service area. Where this is not feasible, organisations may use informed clinical estimates if necessary, although it is advisable to retain hard copy evidence of the data source.

Community Mental Health Teams supporting Mental Health Consultant Non-Specialist Services (Outpatient & Community Setting)

720 These teams are generically known as Community Mental Health Teams (line 14 on Financial Mapping collection guidance), but for Reference Costs purposes are sub-divided into the same categories as for Consultant Services (Outpatient & Community Setting) & Consultant Specialist Services (Outpatient & Community Setting) as these teams comprises the support for such consultant activity.

Sub-categories:
Adult-Drug & Alcohol Community Team
Adult – Other Services Community Team *(includes Rehab Community Team)*
Childrens-Drug & Alcohol Community Team
Childrens-Other Services Community Team
Elderly Services Community Team
Autistic Spectrum Disorder Community Team
Adult Eating Disorder Community Team
Childrens Eating Disorder Community Team
Mother & Baby Community Team

721 Often, consultants who do **not** have a clinical caseload within **specialist teams** such as Crisis, spend part of their time (in addition to Ordinary Admission (Elective or Non-Elective) & outpatient sessions) with Community Mental Health Teams (CMHTs). Their CMHT input is often in an advisory/review role & does not involve patient contact. In such circumstances, an apportionment of consultant cost should be made to the CMHT but there will not be any consultant activity attributable to the CMHT.

722 If the consultants have a clinical caseload within a **specialist team**, the consultant costs & activity should be reported within those of the **specialist team** (see Mental Health Specialist Teams, paragraph 606 onwards) e.g. a Childrens & Adolescent Mental Health Services Team where consultant caseload is part of the team, rather than an outpatient attendance.

723 Community Mental Health Teams are multidisciplinary teams of variable sizes, often comprising a combination of qualified & unqualified staff from different disciplines. The unqualified staff often provide regular contact with clients to improve a particular aspect of their condition – often in a group setting.

724 In addition to the activity & costs of face to face CMHT contacts, it is necessary to identify the activity and costs associated with non-face to face CMHT activity. Please note that 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. A non face to face contact should replace the need for a face to face contact. Telephone contacts solely to inform patients of results are excluded. 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.

725 For CMHT Teams, the 'discipline' is not actually the Community Mental Health Team (CMHT), but rather the qualified professional staff group within each CMHT e.g. Community physiotherapist, speech therapist, occupational therapist etc

726 Although the occasion where a patient would meet more than one discipline at a single time is rare, when this does occur, the reason is for very different purposes and therefore this should be recorded for Reference Cost purposes as such.

The diagram over the page describes this process:

The 'Discipline' = professional staff group (qualification) within each CMHT
e.gs. A Psychologist, Physiotherapist, Speech Therapist within Drugs & Alcohol, Eating Disorders etc

Disciplines Meeting	No. Patients	Professionals	Report As
Discipline A →	1 patient	Same Discipline 1 Professional	1 Face-to-Face patient contact
Discipline A → Discipline A →	1 patient	Same Discipline 2 Professionals	1 Face-to-Face patient contact
Discipline A → Discipline A →	1 patient 1 patient	Same Discipline 2 Professionals	2 Face-to-Face patient contacts
Discipline A → Discipline B →	1 patient	Different Discipline 2 Professional	2 Face-to-Face patient contacts
Discipline A → Discipline B →	1 patient 1 patient	Different Discipline 2 Professional	4 Face-to-Face patient contacts i.e. 2 F-2-F per patient

727 The exception to the general principle above is when 2 (or more) professionals from the same discipline meet a single patient, at the same time, **but for a different purpose.** This is treated as shown below:

Discipline A → Discipline A →	1 patient	Same Discipline 2 Professionals **Different purpose**	2 Face-to-Face patient contacts

728 Note that face to face AND non-face to face contacts are those with the patient, rather than with personnel about the patient. Also note that DNAs are not valid activity for this area of the collection, nor will such activity form part of the collection requirements. To maintain consistency with the Data Dictionary definitions for counting 'contacts', the Reference Cost currency is **PATIENT** contacts.

Note that where a patient receives treatments as if a child, adult or elderly patient, costs and activity of such treatment should be reported in the relevant category, irrespective of whether the patient is technically classed as a child, an adult, or an elderly patient.

729 As per previous years, where Community Mental Health Teams comprises Social Services funded Social Workers in addition to NHS funded CPNs, Psychologists, OTs etc., the cost and activity of the NHS funded staff should **be included in the Reference Cost return.** This change has been implemented to ensure clarity and provide a truer reflection of Trust costs.

Mental Health Specialist Teams

730 The 2010-11 collection requires separate unit cost and activity data to be reported for a variety of services undertaken by Mental Health Specialist Teams (MHST's). The categories that will form part of this collection are based on those used in the 2008/09 financial mapping LIT collection. This is in order to utilise information that is already reported to the Department of Health by mental health services providers. In 2010-11, as previous years collections, each of the services listed below should be split by Child, Adult and Elderly team contacts. Again, this makes the treatment of data consistent with the LIT returns.

731 Where consultants have a clinical caseload within a **specialist team** (MHST) e.g. Crisis, Assertive Outreach, Early Intervention, the consultant costs & activity should be reported within those of the team.

732 The categories are identified as follows (references in brackets refer to Financial Mapping LIT collection guidance and definitions):-

- Crisis Resolution Home Treatment Teams (Line 17)
- Assertive Outreach Teams (Line 18)
- Early Intervention in Psychosis Services (Line 19)
- Homeless Mental Health Services (Line 20)
- Emergency Clinics/Walk in Clinics (Line 21)
- A&E Mental Health Liaison Services (Line 22)
- Crisis Accommodation Services (Line 23)
- ASW Services (where NHS Funded) (Line 24)
- Emergency Duty Teams (Line 25) NB. These are not Emergency Assessments e.g. for sectioning under the MH Act, as such contacts are recorded & paid for separately by PCTs, not under the provider trust contract.
- Children & Adolescent Mental Health Services Teams (NB. Not part of Adult LIT return, but in some Trusts has a Team approach as per Crisis, Assertive Outreach, etc)
- Adult Drug & Alcohol Teams (NB. Not part of Adult LIT return, but in some Trusts has a Team approach as per Crisis, Assertive Outreach, etc)
- Childrens Drug & Alcohol Teams (NB. Not part of Adult LIT return, but in some Trusts has a Team approach as per Crisis, Assertive Outreach, etc)
- Other Mental Health Specialist Teams (to be used where no LIT mapping information is available)

Where an organisation reports an entry in the 'Other Mental Health Team' category they must indicate the nature of the service in the **Statement Z**.

Given the upcoming change in focus for Mental Health Activity, further work will be undertaken by PbR Development in terms of developing new clusters/currencies for future collections. For the purpose of the 2010-11 years collection, please report as follows;

Criminal Justice Liaison Team – Within the MH Specialist Teams Worksheet – Other MH Specialist Teams – Code MHSTO

Forensic Outpatients – Within the MH OP Attendances Worksheet - Mental Health Consultant Services (Outpatient Setting) - First Attendance Face to Face – Adult Other – Code MHOPFAA2

733 In addition to the activity & costs of face to face Specialist Team contacts, it is necessary to identify the activity and costs associated with non-face to face Specialist MH Team activity. Please note that 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. A non face to face contact should replace the need for a face to face contact. Telephone contacts solely to inform patients of results are

excluded. 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.

734 As per previous years, in **all instances**, the unit cost of a face to face contact, and the unit cost of a **non-face to face contact should be reported separately**. Similarly, the total number of face to face **AND non face to face contacts should be reported separately**. Note that face to face AND non-face to face contacts are those with the patient, rather than with personnel about the patient. Also, note that DNAs are not valid activity for this area of the collection, nor will such activity form part of the collection requirements.

735 Some contacts by Mental Health Specialist Teams do not meet either the criteria of 'face-to-face' and/or 'non-face-to-face' i.e. contacts with carers, other health professionals, multi disciplinary team meetings about the patient. Such contacts need to be excluded from the counted activity in the Reference Cost submission. However, you will need to include the costs in apportioning the full cost of providing the Mental Health service between the two criteria as per the NHS Costing Manual.

736 As per previous years, as the Data Dictionary now states that if 2 staff (e.g. in a CMHT) meet with a patient simultaneously for the same purpose this counts as 1 contact. The Reference Cost currency is no longer TEAM contacts, but rather **PATIENT contacts** as such this scenario will count as 1 face-to-face patient contact (as in the diagram above) . Please note, as stated in section 4, that A&E Mental Health Liaison Services should not be included in the A&E activity – and should be reported under Mental Health Specialist Teams only.

737 Data reported should be reconciled to the categories used in the LIT return and split by Elderly/Adult/Child in 2010-11 as per **where the patient receives treatment**.

- Services provided to children should be reported within the composite costs and activity of each relevant category, where possible. Where services provided to children cannot be identified by LIT category, the 'Other Mental Health Specialist Teams : Child' category should be used for all costs and activity relating to specialist mental health teams dealing with patients up to and including 20 years old.

- Services provided to the elderly (aged over 65) should be reported within the composite costs and activity of each relevant category, where possible. Where services provided to the elderly cannot be identified by LIT category, the 'Other Mental Health Specialist Teams: Elderly' category should be used for all costs and activity relating to specialist mental health teams dealing with elderly patients.

- 'Mother and Baby' Community Teams which support Consultant Outpatients should be reported as 'CMHTs supporting Mental Health Consultant: Mother and Baby Community Team', as per paragraph 703-705. But Mother and Baby Specialist Mental Health Teams that have consultants with a clinical caseload within the Team should be reported in 'Mental Health Specialist Teams: Adult Category'.

- 'CAMHS' Teams that have consultants with a clinical caseload within the Team should be reported in 'Child and Adolescent Mental Health Services Teams', as per paragraph 608.

  NB: Any team which supports Consultant Outpatients (rather than have consultants within the team) should be reported as per paragraph 703-705 i.e. 'CMHTs supporting Mental Health Consultant'.

738 Due to the anticipated volume of data involved, and the paucity of automated recording systems for the majority of community-based mental health services, it is acceptable that organisations use appropriate and reflective sample data to ascertain annual activity for Mental Health Specialist Team services. There is no minimum sample time stipulated within Reference Costs; rather, the sample should be reflective of annual activity undertaken within a service area. Where this is not feasible, organisations may use informed clinical estimates if necessary, although it is advisable to retain hard copy evidence of the data source.

Regular Attendances at Mental Health Day Care Facilities

Day Care Facility

739 A range of services are provided through NHS day hospitals/centres/units. Primarily these provide services for the elderly and rehabilitation services as well as mental health and learning disability patients. Often patients attend these hospitals/centres 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 and over 5 days this gives 100 patient days. Likewise if a patient attends one day per week for 26 weeks this equates to 26 patient days.

740 Confusion has sometimes arisen as to whether a regular contact with a client constitutes a CMHT (group) contact or a Day Centre attendance. It is usually considered that Day Centres have consultant input & undertake patient assessments, whereas a CMHT (group) contact would not necessarily involve a consultant & would not involve patient assessments.

741 There has been some inconsistency in reference costs to date with some providers including these services in the collection and others omitting them in both activity and cost terms. From 2003 onwards, the costs and activity for these day hospitals/centres/units formed part of the collection for elderly, stroke, and mental health services. Centres catering primarily for the long term physical disabled and learning disability patients are still excluded (as all other services for these patient categories are also excluded).

742 Discussions have identified that little patient specific information is routinely recorded for patients attending these units/hospitals. However, in an attempt to try to distinguish categories for reporting mental health day care facilities, the 2010-11 collection subdivides the single category of previous years into three, 1 for each of:

- Child;
- Adult; &
- Elderly.

743 Where data is unavailable to enable separate reporting by consultant specialty, all activity and costs should be reported as 'adult'. The basis for inclusion will remain as the total number of patient days and a unit cost per day, for each category. Where patients attend for only part of a day, a conversion should be made from a part day attendance to a patient day e.g. a morning only attendance = 0.5 patient days.

744 Although it is acknowledged that a range of services/interventions can take place during each day, and this is determined by each patient's condition, this development is seen as being the first stage in introducing these services into the reference costs collection.

745 Note that any additional costs that are incurred when an Ordinary Admission (Elective or Non-Elective)) concurrently attends a day care facility (and where their bed is not filled, but is retained for their later use) should be removed from the total cost of the day care facility and be reported as part of the composite cost of that Ordinary Admission (Elective or Non-Elective)) occupied bed day. No day care facility activity should be counted for such patients.

This ensures that the:

- Reported costs of Ordinary Admissions (Elective or Non-Elective) (on an occupied bed day basis) are fully reflective of the costs incurred by such patients;
- Ordinary Admission (Elective or Non-Elective) is not double-counted in activity terms (e.g. as an Ordinary Admission (Elective or Non-Elective) occupied bed day and a day care facility attendance)
- Costs of the day care facility are not overstated.

Thus:

- The total cost of the day care facility must therefore reflect the total cost of the service, less those costs that relate to Ordinary Admissions (Elective or Non-Elective) attending the day care facility.
- The total activity of the day care facility must therefore reflect the total activity of the day care facility, less the activity relating to those patients who attend but are also currently admitted to that NHS provider as an Ordinary Admission (Elective or Non-Elective).

- Dividing this adjusted total cost by the adjusted activity will produce an appropriate unit cost per patient day for the day care facility.

  The above principle also applies to Mental Health Ordinary Admissions (Elective or Non-Elective) that attend outpatient clinics whilst being an admitted Ordinary Admission (Elective or Non-Elective) (adjust cost and ensure activity is not double-counted). Thus, no outpatient activity should be counted for admitted Ordinary Admissions (Elective or Non-Elective).
  In certain circumstances, it may be applicable to non-mental health Elderly day care facilities, where treatment is similar.

746 In the preparation of cost and activity data for these services, the service definitions included in the Mental Health Service mapping exercise should be used. These can be found on at websites:

- Adults: http://www.mhcombinedmap.org/Support.aspx and
- Older People http://www.mhcombinedmap.org/Support.aspx

Changes to the Specialist Mental Health Teams collection is an initial move towards bringing the financial mapping exercise and reference costs closer together where this is feasible.

747 Work continues to bring Mental Health services into the scope of PbR. Increased refinement and the extension of the services included can be expected in the future. Full details of the collection for these services can be found in Appendix 8 of the NHS Costing Manual.

SECTION 14

COMMISSIONED/SUB-CONTRACTED WORK FROM NON-NHS & VOLUNTARY HEALTH SECTORS

748 Under the Concordat arrangements, a higher focus has been given to the use of the private sector in delivering care to NHS patients. This is only one aspect of the relationship with the NHS however.

749 Commissioners have set contracts for delivery of care with the private and voluntary sectors for several years. These have ranged from local agreements with an independent GP to extend a service across patients for a group of services (beyond GMS requirements) to an agreement for set volumes of activity each year with a local private hospital. In addition, patients based in voluntary sector establishments such as hospices, SCOPE, MIND, etc., are also widespread, although work subcontracted or commissioned from the voluntary sectors is still **excluded** from this collection.

750 NHS providers have also sub-contracted work to the private/charitable sector in a number of circumstances such as meeting waiting list targets, and emergency mental health admissions.

751 In 2007/08, NHS providers who sub-contracted work from outside of the NHS (i.e. both private/charitable sector organisations), were required to separately identify this activity and cost at a more detailed level. For all services/providers, the level of detail is the same as for the provision of their own services. This assisted in confirming the suspected cost differentials between different sectors, and avoided cross-subsidisation of costs between different types of providers.

752 The requirement to separately identify resource use by NHS organisations for NHS patients outside the NHS continues in 2010-11. As in previous years, NHS organisations will be required to provide a single set of composite collection files, which combine unit cost and activity data for non-NHS providers from whom they acquire health services.

753 There is no requirement to separately identify work sub-contracted to other NHS providers.

754 If work undertaken by the private/charitable sector was only reported by NHS providers, the overall levels of activity and cost for NHS patients would be understated.

755 As a general guide, PCTs and NHS Trusts tend to sub-contract activity to non-NHS providers where they are unable to meet capacity requirements / external targets such as waiting list initiatives, etc. Only PCTs can legally commission services, and generally, they do not provide the services that they commission directly from non-NHS sources.

756 At this stage, all activity commissioned from and delivered by some areas of the Charitable and Voluntary sector continues to be outside the scope of reference costs. This exclusion covers the work of hospices and charitable organisations as specified in the excluded list in Section 16 of this document.

SECTION 15

NON-CONTRACTUAL INCOME

757 One of the most significant items that impacts on the overall reference costs quantum is the level of non-contractual income that an NHS provider receives.

758 In comparing and benchmarking costs, this income can have a distorting effect on the range of costs for given treatments and procedures. Under the NHS Costing Manual, these forms of income have to be matched to the services to which they relate. Therefore, if Trust A receives £1m Research and Development funding and Trust B receives none, all other things being equal, the quantum for Trust A is reduced. Consequently, this will impact on the reference costs unit cost data.

759 In trying to explain cost variations between providers for the same treatment, therefore, the level of these alternative income streams can have a significant impact.

760 As in previous years, the reference costs collection continues to include information on the overall levels of funding from non-contractual income. This data forms part of the reconciliation statements in 2010-11 (Provider Services Statement – PSSY)

761 The collection requires the actual sums received (in £) for 2010-11 financial year from the following areas : -

- National Child Care Strategy
- Improving Working Lives Initiative
- NVQs and NHS Learning Account
- Continuing Professional Development
- Service Increment for Teaching
- Medical and Dental Education and Training Allocations (previously MADEL)
- Nursing and Midwifery Education (previously NMET)
- Assisted Reproduction Medicine data (see paragraphs –84-89)
- Other Income Received
- Other Charitable Contributions

762 Note that income relating to Trust Funds is **not** required in 2010-11.

763 Summary points to note with regard to the treatment of income are as follows :-

- The treatment for each of these income sources should be the same as in previous years; the income should be matched to the relevant expenditure and netted off from the reference costs quantum of costs.
- The income should not be excluded from the reference costs, as to do so, would increase the total expenditure submitted as part of the reference costs returns by in excess of £1 billion in the collection and affect data comparability.

764 Primary Care Trusts with teaching status or having other non-contractual income should also complete this part of the return. No differentiation is made between PCTs and any other NHS Provider having teaching status. The standard NHS Costing Principles on the treatment of these income streams should be applied consistently.

765 Concerns have been raised by the NHS regarding the types of income that should legitimately be classified as Category C, and thus netted off from the reference costs quantum. Appendix 4 of this document provides details of those items that are allowable as Category C (i.e. can be netted off the Reference Costs Quantum of Costs) in 2010-11. This should ensure that there is greater consistency in Category C income classification, and thus impact, in future reference costs collections.

SECTION 16

SERVICES EXCLUDED FROM REFERENCE COSTS

766 Services are excluded from Reference Costs for a number of reasons, This section provides more information about which services, or parts of services, should be excluded. The reasons why data should be excluded vary but might include:;

- No national requirement to know costs (e.g. aromatherapy).
- Lack of clarity as to the unit that could be costed (e.g. learning disability services).
- No clear national definitions of a services (e.g. intermediate care)
- Overlaps with social care funding (e.g. support service equipment).

We are continually reviewing the exclusions list with a view to updating where appropriate and necessary. Please make us aware of any exclusions that are problematic for you locally or that do not appear to make sense.

767 The focus of the 2010/11 collection *continues to be one* of consolidating current collection requirements, and improving data quality where possible. However, work has *again* been undertaken within the Payment by Results team to review exclusions for 2010/11 which has resulted in a number of changes being made to this section of the guidance.

768 The lists below are by no means exhaustive, and should be read in conjunction with Appendices 2 – 5 of this document. Where queries concerning a particular aspect of service inclusion or exclusion arise, please contact the Costing section of the PbR team at the Department of Health, for clarification. Please do not exclude services that are not listed, on the basis of historical reporting convention, without checking.

769 For information, the provider statement of services excluded (PSSC) that forms part of the mandatory cost reconciliation workbook will itemise specific service areas that are excluded from Reference Costs 2010/11. Note that this form requires identification of the activity measure being reported. This information is then used to try to determine whether there are any activity measures currently in use in the NHS that could be adapted as appropriate currencies for future collections. As in previous years there will be the facility to add additional lines in order to capture services not already listed.

770 The total costs of services excluded should be calculated using total absorption costing, and should therefore reflect the entire cost of the service excluded from reference costs, rather than just the direct costs of that excluded service.

771 **Services Excluded (reviewed for 2010-11 Guidance)**

- GMS services (all)
- Health promotion and prevention – see links below (where separate services). This does not include 'patient education for existing conditions' e.g. nurses showing patients how to administer their own drugs.
  www.datadictionary.nhs.uk/data_dictionary/attributes/h/health_promotion_programme_aim_de.asp?query=Health%20Promotion&rank=75&shownav=1
- HM Prison related health services
- Learning Disability Services
- Lymphodema Outpatients Service
- NHS Direct (irrespective of NHS provider)
- Photopheresis [highly specialist service - two providers only (Clinical Haematology department @ The Rotherham NHS Foundation Trust and St John's Institute of Dermatology @ St Thomas Hospital London)]
- Pregnancy Advisory Service (discrete counselling)
- Psychology service, where discrete (including neuro-psychology. Note that where neuro-psychologists are providing treatment as part of 'routine' care, they should be treated as an on-cost to the neurology service)

- Psychotherapy (discrete service)
- Services for the Physically Disabled (e.g. Young disabled centres)

772 **Elements of Service Excluded (reviewed for 2010-11 Guidance)**

- Admission Prevention Schemes (Community-based) not covered by new specialist nursing category 'Active Case Management' (including Community Matrons/Admission Avoidance (see Section 6)
- Audiology Services as defined in Section 10
- Helicopter Emergency Medical Services
- Artificial Eye Fitting (The specialist [discrete] artificial eye fitting service provided by an Ocularist [including making, fitting & aftercare checks on the artificial eyes) are excluded, but any preparatory surgery, etc will be included within the admitted patient care costs and activity).
- CBRN costs for NHA Ambulance Service providers [Note that only pure CBRN costs and activity can rightly be excluded from Reference Costs. The elements of cost / activity that relate to non-pure CBRN items should be included in Reference Costs].
- Cochlear & Bone Anchored Hearing Aid Outpatient Maintenance
- Decontamination Services/units provided by NHS Ambulance Service Providers only
- Domiciliary Visits that attract a fee for the additional service (apart from Mental Health domiciliary visits that are included in community activity). Normal domiciliary visits undertaken by community / other nurses / therapists for which they are not paid an additional fee are included in Reference Costs
- Home Delivery of Drugs where no activity takes place.
- Intermediate / Continuing Care (including Mental Health Services)
- Methadone Swallow and Depot Injection Clinics
- MH Counselling and Therapy (except those services provided through day centres/hospitals)
- Multi-Professional Triage Teams
- Needle Exchange Schemes
- One Stop Shops / Rapid Diagnostic Packages (including advice centres)
- Primary dental service are excluded (inc all elements of the new PCT Dental contract)
- Specialist Services for the Deaf
- Spinal Care Packages in the Community
- Step Down beds in residential facilities
- Vaccination programmes that are part-funded by non-NHS providers (including GPs).
- Well/Healthy babies – activity excluded, costs reported as part of the total costs of the maternity delivery episode [this includes HRG PB03Z and TFC 424]

773 **Support Services Excluded**

- Community Residential Care Homes
- Discrete External Aids & Appliances Services (e.g. artificial limb/eye services, shoes and wigs)
- Home Equipment Loans
- Medical Loans
- Nursing Homes
- Resettlement Programmes (adult & elderly)
- Section 28a Homes
- School exclusion services
- Healthy Start (Previously known as Welfare Foods)
- Wheelchair services.

774 **Other Exclusions**

- All Charities for People with Learning Disabilities, e.g. SCOPE
- All Charities for Physically Handicapped Services
- Clinical trials (unless the costs incurred are an accurate indication of what the actual costs of that treatment would be, outside the clinical trial setting. If the impact of income for clinical trials is such that to net it off would produce unrealistically low, zero or negative costs (i.e. surplus income), the costs and activity relating to such trials must be excluded)
- Emergency Dental Services
- GP open access, e.g. where patients access open access services provided by GPs, NOT open access services whereby GPs refer patients to Trusts.
- GP Out of Hours service (not including where NHS ambulance provider has taken over the responsibility of providing this service from GPs).
- Hospice Movement
- MIND
- NHS LIFT set up costs only
- Personal Dental Services (PDS) pilots
- PFI set up costs only – see Appendix 5 for further details
- Pooled / Unified Budgets
- Private Patients (also includes military patients, where funding for treatment of these patients is received from the MoD. Note that the income received from the MoD should be netted off, rather than the costs incurred in treating these patients being excluded. Note also that to exclude the costs and net off the income received for such patients is not allowable; to do so would understate the quantum of costs by effectively 'double-netting off').
- Other Non-NHS funded patients e.g. failed asylum seekers not entitled to NHS treatment, EU citizens – not NHS funded)
- Social Services (unless specifically stated above).
- Voluntary first responders utilised by Ambulance NHS providers

Pooled / Unified Budgets (including Section 31 Agreements) – reiteration of current treatment

775 As a general principle, the costs and activity for any and all services jointly provided under Pooled / Unified Budget arrangements with Agencies outside the NHS (e.g. Social Services, Housing, Employment, Education, etc.) are to be excluded from the Reference Costs 2010-11

776 Where organisations are confident that they ;

- can separately identify a discrete element of the service that is funded by the NHS, &
- that they can identify the total costs incurred by that service; &
- have accurate and reflective activity data

they can choose to include that service. Such decisions should be defendable to Auditors.

Change in Treatment of Screening Services for 2010-11 Reference Costs Collection

777 For the 2010-11 Reference Costs Collection, the PbR Development Team has provided clearer guidance on how Screening Services should be treated.

778 As a result of the change in treatment, the blanket exclusion of national screening programmes should no longer apply (although some specific programmes will remain excluded). Below is a guide on how Screening Services should now be treated.

UK National Screening Committee Programmes

Antenatal

NHS Fetal Anomaly Screening Programme (**please note this is not excluded** and **should be included in relevant maternity outpatient and inpatient costs**).

NHS Infectious Diseases in Pregnancy Screening Programme (should be included in relevant maternity outpatient and inpatient costs).

NHS Sickle Cell & Thalassaemia Screening Programme (should be included in relevant maternity outpatient and inpatient costs). Exception is for the small number of genetic tests that occur – the cost of these tests are excluded and should be funded direct by PCTs.[5]

Newborn

NHS Newborn & Infant Physical Examination Screening Programme (included in the cost of maternity delivery HRGs or postnatal visits)

NHS Newborn Blood Spot Screening Programme (included in the cost of maternity delivery HRGs or postnatal visits)

NHS Newborn Hearing Screening Programme (already collected separately in reference costs under currency code ASNNS)

Young person/adult

NHS Abdominal Aortic Aneurysm Screening Programme (screening line - line 75 in PSSC sheet of RECON workbook)

National Screening Programme for Diabetic Retinopathy (already collected separately in reference costs under currency code DA11)

NHS Breast Screening Programme (screening line - line 75 in PSSC sheet of RECON workbook)

NHS Cervical Screening Programme (screening line - line 75 in PSSC sheet of RECON workbook)

NHS Bowel Cancer Screening Programme (screening line - line 75 in PSSC sheet of RECON workbook)

Other screening

NHS Health Check for vascular risk (screening line - line 75 in PSSC sheet of RECON workbook)

Chlamydia Screening – Excluded from reference costs.

Prostrate Screening – Excluded from reference costs.

[5] For further information see:
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_104835

APPENDIX 1

REFERENCE COSTS – A BEGINNER'S GUIDE

We hope this will provide some helpful tips and a logical approach for anyone who is new to Reference Costs.

Key Questions

What is the Deadline for Submission?

The deadline for submission is shown below:

Reference Cost Submission Timetable 2010-11

	Begins	Ends
Local Validation Period	04/07/2011	08/07/2011
Collection Period	11/07/2011	22/07/2011

Update Unify2 system guidance detailing where and how to access/use the 2010-11 Reference Costs Collection / Submission website will be issued to NHS Reference Costs leads in May 2011.

What Guidance is Available?

There are three essential documents that you will need.

I. This document – the reference cost collection 2010-11, which provides specific guidance on reference costs for the 2010-11 collection;
II. The NHS costing manual (updated in 2010-11) which sets out the principle for costing in the NHS; and
III. Unify2 System collection guidance (aid to submitting your data into new system)

They will all be available either from the reference cost website or the Unify2 Discussion Forum:

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/NHScostingmanual/index.htm

http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx

Key Contacts?

Each SHA has a designated Reference Cost lead. A regularly updated list of these is available at:

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/NHScostingmanual/index.htm

All queries regarding reference costs should be addressed to your SHA lead in the first instance. Foundation Trusts can also direct queries to the SHA or directly to the PbR Team.

Local costing groups have been set up across the country. These are a good way of meeting other reference cost leads and sharing issues / problems. Your SHA lead will be able to provide details of such groups.

Another way to find out information is on the discussion forum website. This is an **informal** website, used to ask the advice of other NHS costing colleagues.

The (universal) login / password is (all lower case) '**refcosts03**' & '**smile**' (and can be accessed by clicking on following link:
http://www.info.doh.gov.uk/fd/refcostsdisc.nsf/main?readform

The Discussion Forum site is intended for the sharing of knowledge between NHS personnel. DH may also use the notice board area of the site to post FAQs relating to the latest collection guidance. If you require a specific response on a query, you need to contact your SHA leads in the first instance.

Starting Points for Reference Costs

Activity

This reference cost guidance sets out the activity requirements for 2010-11. As a starting point, we recommend that you work through the guidance to determine which services your organisation provides and how that activity needs to be counted for reference cost purposes. You will then need to find out whether that activity information is already collected.

If data is not available, a sample or clinical estimate is acceptable for some services (as indicated in relevant sections in the 2010-11 guidance), although actions should be put in place to collect the data for the following year. Information should be kept for audit purposes if a clinical estimate is made.

As a general rule, you should include all activity data that your organisation undertakes unless the reference cost guidance explicitly states that it should be excluded. We suggest that you liaise closely with your information department to ensure that all activity data is captured and that the activity submitted is an accurate reflection of the activity data reported by your organisation in other activity returns such as HES, Korner, LDP and signed SLA. Please note that the data in these returns may not exactly match your reference costs data and it may be necessary to provide a reconciliation between the various sets of data for audit purposes.

For admitted patient care and outpatients, a download from your patient administration system will be required. This data then needs to be run through the software detailed below to group OPCS and ICD10 codes to HRG codes.

It is also important to note that before the activity download is fed through the HRG4 2010-11 Reference Costs Grouper, certain adjustments are required. These include excluding FCEs relating to well babies and excluding FCEs and bed days for activity where the costs and activity are reported separately for reference costs, such as rehabilitation.

The Grouper software will be available through the Information Centre website following publication, it is expected to become available at the following link:

http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/costing

This software is updated regularly, therefore, you should check the Information Centre website to ensure you are using the correct version for the reference costs collection exercise.

Trimpoints are required for use with the HRG4 2010-11 Reference Costs Grouper (all activity over the trim point should be costed as excess bed days). The FCE and Spell based Trimpoints for the 2010-11 collection will be available from April 2011.

Costing

The full principles for costing in the NHS remain within chapter 2 of the NHS Costing Manual. The fundamental principle is that reference costs should be produced using full absorption costing. This means that each reported unit cost will include the direct, indirect and overhead costs associated with providing that treatment / care.

- *Direct costs are those which are driven by patient type*
- *Indirect costs are those costs which cannot be directly allocated to a particular patient or cost centre*
- *Overhead costs are the costs of support services that contribute to the effective running of a health care provider*

The costing of all services delivered by NHS providers should be governed by the following principles, costs (and income) should be:

- *calculated on a full absorption basis to identify the full cost of services delivered;*
- *allocated and apportioned accurately by maximising direct charging and where this is not possible using standard methods of apportionment;*
- *matched to the services that generate them to avoid cross subsidisation.*

The costing process should also be transparent with a clear audit trail.

The costing guidance states that as far as possible, costs should be directly allocated to specialty level. Where this is not possible, appropriate apportionment methodology should be used. The costing manual provides guidance on appropriate apportionment methodology and the treatment of indirect and overhead costs.
Given maintained audit involvement for 2010-11, it is vital that decisions and processes undertaken in apportioning costs are defensible.

There are three key elements in the costing methodology which are required as NHS providers move along the costing continuum (further details on these can be found within Chapter 2 of the Costing Manual):

- *a "high level control total" based on actual costs by services identifying direct, indirect and overhead costs in line with the national minimum standards. The national high level control totals should be able to be mapped to the national classification found in the current reference costs guidance.*
- *a continuous reconciliation process at all stages of the costing process is required to ensure all costs are recovered, and that costs can be matched to relevant services and final accounts.*
- *a "resource profile" analysis of the key conditions which represent a minimum of 80% of the high level control total in both activity and cost terms. Specific reference should be made to clinicians' and nurses' knowledge of the:*
    - *conditions they treat*
    - *frequency with which they are performed*
    - *resources used to perform them.*

We would suggest that the starting point for costing should be the month 13 ledger download. The TRU / PCT reconciliation illustrations (see Appendices 2 and 3 of this Guidance) provide details on how to calculate the correct quantum of costs for inclusion in your reference cost submission. You will need to provide details of your reconciliation from the reference costs to the final accounts for audit purposes.

For reference cost purposes, category C income is included and therefore netted off against the costs of providing those services to which it is attributable. Information on what constitutes category C income can be found in Appendix 4 of this Guidance. Other categories of income must not be adjusted for in Reference Costs.

Validation of Reference Costs

We recommend that clinicians, general managers and information departments in particular, be fully engaged in the reference cost process.

We also recommend that any decisions taken should be documented for audit purposes, particularly if they involve a departure from existing guidance.

Plan work to allow sufficient time to validate your costs prior to submission to DH. The reference costs have increased in importance; as a result they will form the basis for the national tariff each year. In 2010-11, as in previous years, a data quality report will be available (via web download) for all organisations, shortly after submission. In addition, a verification report, showing all data as submitted and including real time national averages will also be available via web download.

It is important therefore that data submitted in 2010 is as accurate as possible for these real time national averages to be meaningful. If Trusts find material differences in their reference costs they will be allowed to resubmit.

Excluded Services

The main premise in determining whether services other than those identified in relevant guidance or in Provider Services Statement C (PSSC worksheet) are excluded remains, i.e. whether you:

- Provide different services; or
- Provide services differently.

In the first instance, it may be acceptable to exclude such services as being outside the current scope of Reference Costs. Please e-mail such service-specific enquiries to the pbrdatacollection@dh.gsi.gov.uk mailbox for clarification and guidance. Please insert the text “Ref Costs 2010-11 Exclusions query” in the subject title of the email.

Where services are provided differently, there is generally no scope for excluding these from the Reference Costs submission.

Clarification Regarding the 'Type' of Data Submission

There are three choices of type of data submission in the 2010-11 collection:

- 'Owndata',
- 'ContractedOut' and
- 'Commissioned'.

- For NHS Trusts and PMS+ pilot sites, their data submissions will either be ' Owndata ' or ' ContractedOut' (i.e. for services that are contracted out to non-NHS providers, **including Independent Sector Treatment Centres (ISTCs**)).

- For Primary Care Trusts, their data submissions may be ' Owndata ' or 'ContractedOut' (for PCTs acting in their capacity as providers of health care services) or 'Commissioned' (where the PCT directly commissions health care services from outside the NHS, including ISTCs).

  Only PCTs can commission services, therefore NHS Trusts / PMS+ pilot sites should not be submitting 'commissioned' data returns.

Commissioned and Contracted Data Requirements

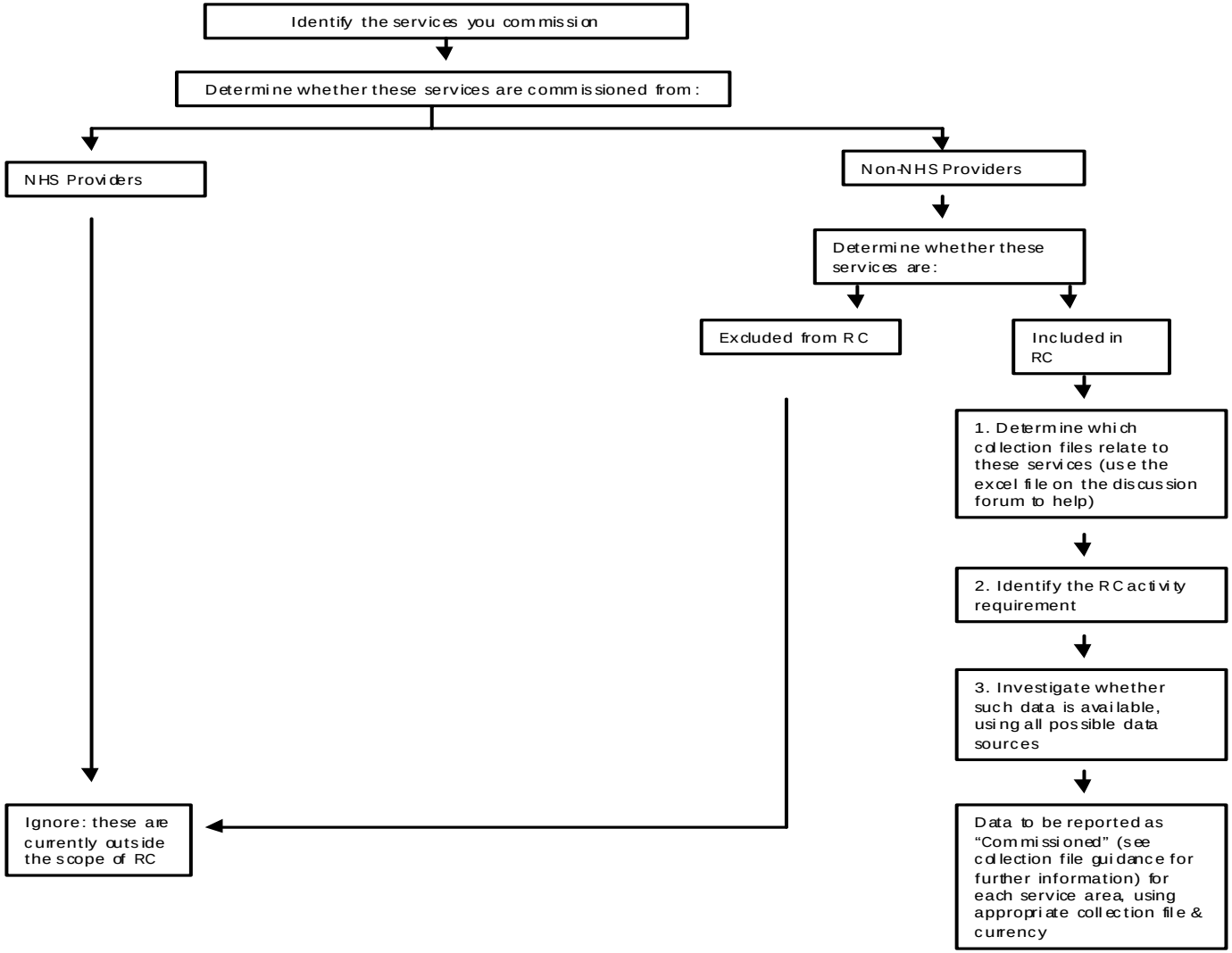
⇨ NHS organisations will be required to produce unit cost and activity data for services that they sub-contract to, or directly commission from, non-NHS providers. They will be required to produce a single composite set of files for all non-NHS providers that they sub-contract with, and, **for PCTs only**, a single composite set of files for those non-NHS providers that they directly commission from.

⇨ As a general rule, PCTs will;
- Sub-contract activity (from their Provider arm) to another provider (either NHS or non-NHS) where they themselves provide the service but have a problem with capacity.
- Commission activity (from their Commissioning arm) directly from another provider (either NHS or non-NHS) where they themselves do not provide the service.

How Does the Process Fit Together?

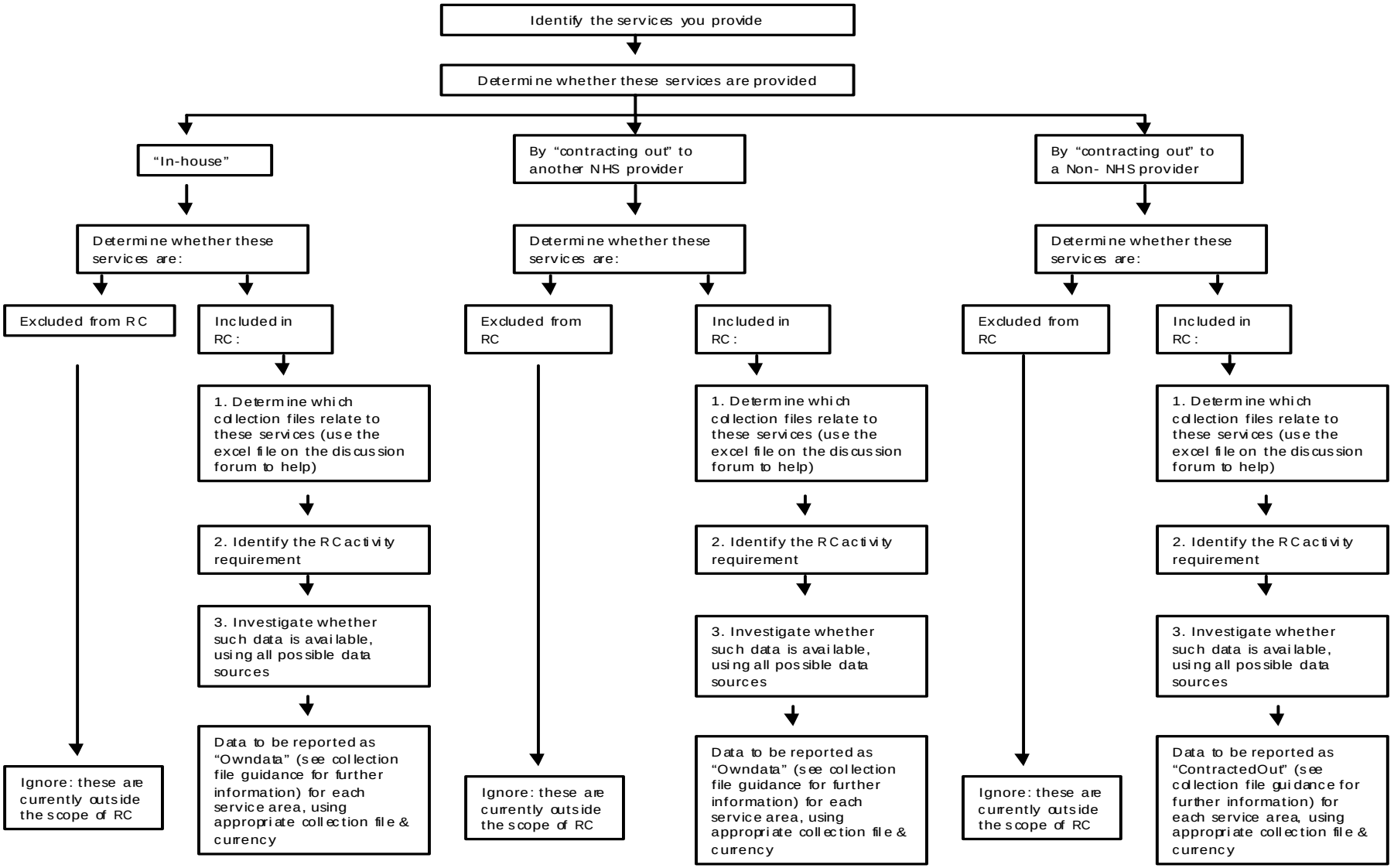
Flow diagrams can be found on the following pages, which attempt to illustrate the investigative process that NHS providers should undertake when determining what and how to submit Reference Costs information.

For Primary Care Trusts Only



Gateway Reference: 15289

For NHS Trusts, FTs, PCTs & PMS+ sites



Please note – Excluded Items are not reported in the main collection but data is required in the Reconciliation Statement as memorandum items

Additional Information for PCTs

Where PCTs are Host Providers and Commissioners

⇨ Where PCTs are host providers of a service for a group of PCTs, who sub-contract the service from the host PCT through their provider arm, the host PCT should not net off the income they receive under provider-provider agreements from each of the other PCTs, but report **all the costs and activity of providing this service** in their own return.

The rule of thumb is that hosted services are all declared by the host PCT, unless they feed into other in-patient or out-patient activity, for other PCTs, in which case relevant costs are included within the unit costs and activity for that (other) PCT.

⇨ Where PCTs are the only providers of a service that is commissioned by a number of PCTs, they **continue to report all the costs & activity of providing this service in their own return** (there is no requirement for PCTs to report costs & activity that they commission from other NHS organisations).

⇨ Where PCTs are host commissioners of a service from non-NHS providers, they report the costs & activity of directly commissioning the service from non-NHS providers in a single (host commissioner's) 'Commissioned' return. Costs and activity should not be disaggregated between the PCTs that the host commissioner has commissioned the non-NHS activity on behalf of.

GPs with Special Interests

⇨ For GPs employed by the PCT, include the costs of and the activity that they provide in PCT 'Owndata' provider submission for outpatients.

⇨ For the GPs that charge you, either;
   a. They're acting in their capacity as part of the NHS therefore include the costs and activity in PCT 'Owndata' provider submission file for outpatients (no requirement to separately identify provider-provider agreements for other NHS providers);
   b. They are acting in their capacity as non-NHS providers therefore include the costs and activity in PCT 'ContractedOut' provider submission file for outpatients (requirement to separately identify and report services where these are sub-contracted to non-NHS providers).

⇨ Where these services are commissioned from the GPs, either;
   a. They are acting in their capacity as part of the NHS therefore ignore the costs and activity and report nothing (no requirement to report services commissioned from the NHS).
   b. They're acting in their capacity as non-NHS providers therefore report the costs and activity in PCT 'commissioned' commissioner submission file for outpatients (requirement to separately identify and report services where you commission these directly from non-NHS providers).

GSUP Activity

⇨ GSUP activity, which is recorded locally but paid for centrally by DH, should be excluded by PCTs as there is no cost to match with the activity.

Expenditure Reconciliation Statement 1 (PSS1)

⇨ Statement 1 is an NHS **Provider** Analysis of Expenditure Statement.
The total cost column should therefore reflect the total provider costs that are incurred by an NHS organisation. This should be split between those costs relating to services currently included in the Reference Costs collection, and those services currently excluded from the Reference Costs collection.
PCTs should not include costs relating to their commissioning role on this statement.

Reconciliation to Accounts and Activity Sources

- ⇨ *When costing services it is important to ensure that the total costs included in the relevant accounts can be reconciled to the quantum of costs used in the activity costing analysis as a check to ensure all appropriate costs have been fully included.*

- ⇨ *In addition activity levels used should be reconciled to available activity data sources e.g. HES/SUS.*

- ⇨ *In producing costs for inclusion in the National Schedule of Reference Costs, the main purpose is to include all costs that relate to the delivery of health services for NHS patients from NHS resources.*

- ⇨ *The full absorption cost principle is therefore applied. The direct, indirect and overhead costs of the services should be included. In addition, NHS providers should ensure that the costs of services should be included even when the service is not directly provided i.e. provider to provider contracts. These contracts can cover clinical services e.g. pathology analysis services, as well as support services. Details of this treatment are found in Chapter 3. The related activity should also be adjusted.*

- ⇨ *The reconciliation analysis statement for expenditure levels used in Reference Costs analysis can be found below in Appendices 2 and 3.*

APPENDIX 2

NHS TRUST RECONCILIATION TO TAC/FTC FIGURES (Please Note – We have been made aware by colleagues within the Department, that these cell references may be subject to change outside of reference costs guidance publication timescales. Any amendments will be reflected in the 2010-11 workbook)

Reconciliation of TRU data to Reference Costs for NHS Trusts.

Line Count		Line Ref	£000's
1	Operating expenses [TRU01]	120	
2	Less: Non NHS: Private Patients [TRU13]	170	
3	Less: Non NHS: Overseas Patients [Non Reciprocal] [TRU13]	180	
4	Less: Non NHS: Other [TRU13]	200	
5	Less: Other operating income [TRU01] [Please see Category C 'allowables' file]	110	
6	Less: Actual Cost of Distinction Awards [please identify separately]*		
7	Add: NHS Injury Costs Recovery [PCT15] [Please Read Note] ***		
8	Less: NHS Injury Costs Recovery bad debts written off		
9	Add: items not allowable as Category C for RC [Please see Category C 'allowables' file]****		
10	Less: Actual Cost of Impairments **		
11	Add: Transfers from reserves in respect of impairments **		
12	Less: Actual Additional costs incurred as result of AfC Early Implementation **		
13	Less: Actual Funds received for Foundation Trust Application **		
14	Less: PFI Exclusions [Please see PFI Guidance file] **		
15	**Total Net Operating Expenditure:**		-
16	Adjustment for Provider-Provider Agreements [All Providers]		
17	**Sub-Total**		-
18	Add: Cost of fundamental reorganisation / restructuring [TRU01]	140	
19	Add: (Profit) / loss on disposal of fixed assets [TRU01]	150	
20	Less: Interest receivable	170	
21	Add: Interest payable	180	
22	Add: PDC Dividends payable	210	
23	Add: Other finance costs - unwinding of discount	190	
24	**Total costs [sum lines 17-23]**		-
	Less: Total costs for services currently excluded from Reference Costs Collection		
	Total Reference Cost Submission Quantum		-

The starting point for costing will be the month 13 ledger download. Any significant audit adjustments should be reflected in the ledger download to ensure that reference costs reconcile to final accounts.

* If reported as part of 'Other Operating Income' in Final Accounts, please add back to line 5 & net off using line 6; please ensure costs are not netted off twice

** Adjustments for these lines should not incur any additional costs apportioned for lines 18 to 24 inclusive

*** Injury Cost Recovery income should not be reported as Category C, therefore included in line 5, ADD BACK therefore if it's included in line 5, it must be added back

**** Some items are not 'allowable' as Category C income for RC purposes. There is a separate file detailing such items. Please check with the central team if further clarification is required.

Due to differences in accounting practice, it is the responsibility of each organisation to ensure adjustments made, are made in line with the above, no double counting occurs - i.e. no netting off / adding back of the same thing twice.

Note: where Provider-Provider agreements have been adjusted prior to determining in line 1, there is no requirement to either re-adjust or separately identify the adjustment in the 'ADJUSTMENT FOR PROVIDER-PROVIDER AGREEMENTS' line of the Reconciliation Statement.

NHS FOUNDATION TRUSTS

Reconciliation of FTC data to Reference Costs for NHS Foundation Trusts.

Line Count		Line Reference	£000's
1	Operating expenses [1. SOCI]	105	
2	Less: Non NHS: Private Patients [6. Op Inc (type)]	140	
3	Less: Non NHS: Overseas Patients [Non Reciprocal] [6. Op Inc (type)]	145	
4	Less: Non NHS: Other [6. Op Inc (type)]	155	
5	Less: Other operating income [6. Op Inc (type)] [Please see Category C 'allowables' file]	275	
6	Less: Actual Cost of Distinction Awards [please identify separately]*		
7	Add: NHS Injury Costs Recovery Scheme [Please Read Note] ***		
8	Less: NHS Injury Costs Recovery Scheme bad debts written off		
9	Add: items not allowable as Category C for RC [Please see Category C 'allowables' file]****		
10	Less: Actual Cost of Impairments **		
11	Add: Transfers from reserves in respect of impairments **		
12	Less: Actual Additional costs incurred as result of AfC Early Implementation **		
13	Less: Actual Funds received for Foundation Trust Application **		
14	Less: PFI Exclusions [Please see PFI Guidance file] **		
15	Less: Bad Debts / Provisions with no applicable income in ledger		
25	**Total Net Operating Expenditure:**		**-**
26	Adjustment for Provider-Provider Agreements [All Providers]		
27	**Sub-Total**		**-**
28	Add: (Profit) / loss on disposal of fixed assets [6. Op Inc (type)]	225,230,235,240	
29	Less: Interest receivable [4. SOCI]	115	
30	Add: Interest payable [4. SOCI]	120	
31	Add: PDC Dividends payable [4. SOCI]	130	
32	Add: Other finance costs - unwinding of discount [4. SOCI]	125	
42	**Total costs [sum lines 27-41]**		**-**
	Less: Total costs for services currently excluded from Reference Costs Collection		
	Total Reference Cost Submission Quantum		-

Please note for FTs licenced part way through the year, the FTC reconciliation will need to be used to obtain part of the reference costs quantum and thei FTC reconciliation used to obtain the remaining element - only one reference cost submission is required

* If reported as part of 'Other Operating Income' in Final Accounts, please add back to line 5 & net off using line 6; please ensure costs are not netted off twice

** Adjustments for these lines should not incur any additional costs apportioned for lines 18 to 24 inclusive

*** RTA income should not be reported as Category C, therefore if it's included in line 5, it must be added back

**** Some items are not 'allowable' as Category C income for RC purposes. There is a separate file detailing such items. Please check with the central team if further clarification is required.

Due to differences in accounting practice, it is the responsibility of each organisation to ensure that where adjustments are made, are made in line with the above, no double counting occurs - i.e. no netting off / adding back of the same thing twice.

Note: where Provider-Provider agreements have been adjusted prior to determining in line 1, there is no requirement to either re-adjust or separately identify the adjustment in the 'ADJUSTMENT FOR PROVIDER-PROVIDER AGREEMENTS' line of the Reconciliation Statement.

In addition note that FRS11 adjustments (per the accounts) should be EXCLUDED from ref costs

use line 10 for local reconciliation

APPENDIX 3

PRIMARY CARE TRUST RECONCILIATION TO PCT FIGURES

Reconciliation of PCT data to Reference Costs for PCTs.

Line Count		Line Reference	£000's
1	Provider gross operating cost [PCT15]	470	
2	Less: Non NHS: Private Patients [PCT15]	560	
3	Less: Non NHS: Overseas Patients [Non Reciprocal] [PCT15]	580	
4	Less: Non NHS: Other [PCT15]	590	
5	Less: Other operating income [PCT15] [Please see Category C 'allowables' file]	640	
6	Less: Actual Cost of Distinction Awards [please identify separately]*		
7	Add: NHS Injury Costs Recovery [PCT15] [Please Read Note] ***	570	
8	Less: NHS Injury Costs Recovery bad debts written off		
9			
10	Add: items not allowable as Category C for RC [Please see Category C 'allowables' file]****		
11	Less: Actual Cost of Impairments ** [PCT14]	410	
12	Add: Transfers from reserves in respect of impairments ** [PCT15]	630	
13	Less: Actual Additional costs incurred as result of AfC Early Implementation **		
14	Less: PFI Exclusions [Please see PFI Guidance file] **		
15	**Total Net Operating Expenditure:**		-
16	Adjustment for Provider-Provider Agreements [All Providers]		
17	**Sub-Total**		-
18	Add: (Profit) / loss on disposal of fixed assets [PCT14]	430	
19	Less: Interest receivable [PCT01]	170	
20	Add: Interest payable [PCTF01]	180	
21	Add: Other finance costs - unwinding of discount [PCT14]	480	
22	**Total costs [sum lines 17-21]**		-
	Less: Total costs for services currently excluded from Reference Costs Collection		
	Total Reference Cost Submission Quantum		-

The starting point for costing will be the month 13 ledger download. Any significant audit adjustments should be reflected in the ledger download to ensure that reference costs reconcile to final accounts.

* If reported as part of 'Other Operating Income' in Final Accounts, please add back to line 5 & net off using line 6; please ensure costs are not netted off twice

** Adjustments for these lines should not incur any additional costs apportioned for lines 18 to 24 inclusive

*** Injury Cost Recovery income should not be reported as Category C, therefore included in line 5, ADD BACK

**** Some items are not 'allowable' as Category C income for RC purposes. There is a separate file detailing such items. Please check with the central team if further clarification is required.

Due to differences in accounting practice, it is the responsibility of each organisation to ensure adjustments made, are made in line with the above, no double counting occurs - i.e. no netting off / adding back of the same thing twice.

Note: where Provider-Provider agreements have been adjusted prior to determining in line 1, there is no requirement to either re-adjust or separately identify the adjustment in the 'ADJUSTMENT FOR PROVIDER-PROVIDER AGREEMENTS' line of the Reconciliation Statement.

- In addition, note that FRS 11 adjustments (per final accounts) should be excluded from Reference Costs - use line 10 for local reconciliation.

APPENDIX 4

CATEGORY C INCOME 'ALLOWABLES'

[Please be aware, this has not been updated for 2010-11 collection – If you require more information please email pbrdatacollection@dh.gsi.gov.uk with your query]

With thanks to Sue Pilkington, Trent Costing Group & Many Many Others!	
Incomes classed as Category C	**Notes**
A&E Patient Experience Fund	**Not acceptable as category C : cannot net off**
Access, Booking & Choice Funding	**Not acceptable as category C : cannot net off**
Advertising	Acceptable
Actual Additional costs incurred as result of AfC Early Implementation [April to September 2004]	**Please exclude costs incurred [not net off income, as income received to date may not fully reimburse costs during financial year]**
Agenda for Change income received for period [October 2004 to March 2005]	**Not acceptable as category C : cannot net off [costs for this period should be included]**
Beverages & Meals	Acceptable
Cancer Network	Acceptable
Cancer Services collaborative	**Not acceptable as category C : cannot net off**
Capital to Revenue Transfers	**Not acceptable as category C : cannot net off**
Car Park Income	Acceptable
Catering Income	Acceptable
Charitable contributions to non pay expenditure	Acceptable
CHD Collaborative	**Not acceptable as category C : cannot net off**
Clinical Audit Funding	**Not acceptable as category C : cannot net off**
Conference income	Acceptable
Consultant Distinction Awards	Acceptable [for RC purposes only]
Copy X Ray Income for legal cases.	Acceptable
Copying/Photography Income	Acceptable
Court Order Admin Fee	Acceptable
Culyer income (R&D)	Acceptable
DOH funding for specific projects e.g. Disability equipment assessment	**Not acceptable, unless targeted income specified in this listing**
Drugs Income for drugs supplied to other Trusts and Pharmacists	Acceptable [expected to be Income from Operations - i.e. Category C]
Drug Trial Income	Acceptable, but associated activity must be excluded from RC [similar treatment to private patients]
Emergency Services Collaborative	**Not acceptable as category C : cannot net off**
External income - research	Acceptable
G P Co - Op Income	Acceptable [expected to be Income from Operations - i.e. Category C]
GH "Restroom" hospitality inc	Acceptable
GH "Restroom" takings	Acceptable
Hospital shop leases	Acceptable
I&E Surplus [from previous year]	**Not acceptable as category C : cannot net off**
Improvement Partnership for Hospitals	**Not acceptable as category C : cannot net off**
Income from "Safer Cities"	**Depends on Income Source**
Income from admin charges	Acceptable
Income From Charity And Others	Acceptable
Income from educational course	Acceptable
Income from hospitality	Acceptable
Income from investments	Acceptable
Income from Lifting	Acceptable
Income from moving & handling	Acceptable
Income from telephones	Acceptable
Income Generation schemes e.g. Use of pool & Physio gym	Acceptable
Information for Health	**Not acceptable as category C : cannot net off**
Information for Health Modernisation Fund	**Not acceptable as category C : cannot net off**
Interest received on cash deposits	Acceptable
Lease Car Income	Acceptable
Lecture fees income	Acceptable
Lodging charges	Acceptable
Maternity Liaison Committee	**Not acceptable as category C : cannot net off**
Misc Sale Of Inventory Items	Acceptable
Miscellaneous Income	Acceptable
Mortuary fees	Acceptable
OT sales	Acceptable
Paycare Commission	Acceptable
Planned in-year non-recurrent support	**Not acceptable as category C : cannot net off**
Prescription income (Pharmacy)	Acceptable
PTP Handling charges	Acceptable
PTP income	Acceptable
PTP income VAT to pay	Acceptable
Receipts in Advance	Acceptable
Recharges to PCTs as contribution to expenditure for NHS Direct	**Not acceptable as category C : NHS Direct excluded, therefore income shouldn't be netted off**
Reclaims/Rebates	Acceptable
Rent & rates deductions	Acceptable
Rent of Land & Premises	Acceptable
Salary recharges to charities , Universities (e.g. for staffing university sessions on the Trusts MRI scanner), Other non NHS bodies eg Clinical pathology Accreditation	Acceptable [expected to be Income from Operations - i.e. Category C]
Sale of baby scan photos	Acceptable
Sale of Scrap	Acceptable
Silver recovery	Acceptable
Social services income Staff	**Not acceptable : if pooled budget arrangements, service should be excluded from RC 2005**
Staff meal deductions	Acceptable
Telephone income	Acceptable
Theatre & Pre-Op Assessment Programme	Acceptable to net off the funding received from the Modernisation Agency to fund the Project management costs of collecting & supplying data on theatre utilisation, etc. to DoH.
Training income (includes NVQ, NMET, SIFT, Madel, PGME, WDC)	Acceptable
Transfer from donated asset reserve to contra depreciation	Acceptable
Transitional Relief	**Not acceptable as category C : cannot net off [it's essentially a negative cost]**
Unclaimed Patients property	Acceptable
Vending Machine Sales	Acceptable
WHO income	Acceptable

- For Reference Costs purposes, Category C income (that can be netted off from the Quantum of Costs) is only **that relating to non-patient-related income;** income should not be netted off simply because it is targeted / specific funding.

- Where allowable category C income relates to services currently excluded from reference costs, care must be taken to ensure that category C income for those services is not netted off; there are no costs (in the submission) to 'match' this income to.

APPENDIX 5

PFI EXCLUSIONS

[Please be aware, this has not been updated for 2010-11 collection – If you require more information please email in with your query]

HEADING	Comment	DH comments on treatment of costs for reference cost purposes.
Unitary Payment		Include
Volume Adjuster	For increases in patient related expdt	Include
Interim Services (incl Pass Thru Costs)	Hard and soft services transferred early	Include
Demolition Costs	Of building in way of new build	Exclude. If the scheme were to be funded through public capital this is likely to be capital expenditure.
LCIM - NHS Bank Claim	Project Co costs for ongoing maint./ replacement of variations, over life of project	
Advisor Fees	External to Trust	Exclude. To clarify the guidance, set up costs (principally fees) can be excluded up to the point of commissioning. If there is a staged programme please provide details to the ref costs mailbox for further clarification.
Project Team	Internal	Exclude. To clarify the guidance set up costs (principally fees) can be excluded up to the point of commissioning. Please make sure that you can satisfy the auditors that the costs of the project team do relate to the time spent working soley on the PFI scheme.
Clinical Sciences Building Running Costs		Include
Accelerated Depreciation		Exclude. Accelerated depreciation and impairments can be excluded but you should make sure that any income received should not be netted off.
Dual Running Costs	For services transferring	Include. Double running costs for all other service reconfigurations etc are included.
Medical Records Store	Not provided for in new build	Include

- As a general principle, PFI set up costs will include one off revenue costs incurred in setting up a PFI scheme from the initial business case stage to financial close. It will include largely fees (consultancy, legal, financial etc) and other costs such as planning applications.
- Queries regarding specific PFI costs should be sent to the pbrdatacollection@dh.gsi.gov.uk mailbox (please insert the text “ref costs PFI query” in the subject title of the email and include a brief description of the costs involved.

APPENDIX 6

2010-11: SUMMARY OF KEY CHANGES

Please note that the following points do not constitute a comprehensive list of changes to the previous Reference Costs 2009-10 guidance and subsequent collection. Rather, they are indicative of the key changes made to the draft guidance for the 2010-11 collection.

As per 2009-10, the process of writing the 2010-11 guidance continues to be one of refinement and improvement and incorporation of new HRGs rather than extension of scope.

Please note that the following points are reflective of those changes/points that will have the most impact on the NHS organisations providing 2010-11 Reference Costs data and are set out in the order as presented in the latest Guidance manual.

Overview

- The main purpose of the Reference Costs collection is to provide a unit cost benchmark in order to provider a proxy measure of relative efficiency. In addition, reference cost information will be used to inform the 2010/11 tariff.

- Reflecting the move towards patient specific cost and income measure the 2010-11 Reference Costs will continue to be produced on the standard FCE basis.

- The Reference Costs 2010-11 collection will continue to use HRG4, which have been refined slightly for this year's collection. The guidance provides a better overview of HRG4 and links to the NHS Information Centre for Health and Social Care.

- Generally, definitions continue to be brought more into line with the NHS Connecting for Health data dictionary where possible.

APPENDIX 6 – 2010-11: Summary of Key Changes

Section	**Para (09-10)**	**Area**	**Significant Guidance / Collection Change** (these are not fully comprehensive, however key changes for 09/10 are identified)	**Para in 10-11 Guidance**
Exec Summary			Combination of Costing Manual/Reference Costs Guidance	Various
1	8	Collection Timetable	Change to collection timetable for 2010-11	12
1,2	43, 101-106	Spells Collection	Spells Based Data Collection – Not mandated for 2010-11	46, 146
2	75-77	Bone Anchored Hearing Aids	Introduction of Bone Anchored Hearing Aid HRGs	105-106
2	N/A	Multiple Trauma	Introduction of new HRG generation methodology for Multiple Trauma	114-117
2	N/A	Gastro Intestinal Tract Endoscopies	Additional guidance for Gastrointestinal Tract Endoscopies	118-121
3	N/A	Genetics	Guidance for reporting Clinical Genetics and Cyto-Molecular Genetics services	200-201
3	161-171	CMDTs	Clarification of guidance for CMDTs (no change to reporting)	202-212
3	253-254	Home Delivery of Drugs	Clarification of guidance for CMDTs & request for further data	317-319
8	350-373	Chemotherapy	Clarification of guidance for chemotherapy (no change to reporting)	423-449
8	418-430	Radiotherapy	Clarification of guidance for radiotherapy (no change to reporting)	493-508
8	479-497	Renal	Introduction of new HRGs for Chronic Renal Dialysis	557-581
8	N/A	Renal	Clarification of guidance for Acute Renal Failure/Kidney Injury	558
8	498-504	PTS	Change to collection of Patient Transport Services	649
13	N/A	Mental Health	Approach for collection of Mental Health not confirmed	684-685

APPENDIX 7

REFERENCE COSTS 2010-11: POINTS TO NOTE

Recording a Service which is Part Funded by Two Different Organisations, for example, an NHS Trust and a Primary Care Trust – Clarification

⇨ The overriding principle for Reference Costs is total absorption costing, so one organisation [either the Trust or the PCT] has to report the full cost of this service, and it ideally should be the organisation that holds clinical responsibility for the patients. E.g. for direct access radiology, if the Trust provide the staff, etc, and the PCT pays for the machine, we would expect that if the patients 'belong' to the PCT, they reimburse the Trust for the costs that it incurs. The Trust would therefore net off this [provider-provider] income, and the PCT would report the entire costs [direct + what they pay the Trust] and the whole activity in the appropriate collection category – e.g. banding if the service is accessed directly by patients.

⇨ Where the split between costs and activity is not so straightforward, e.g. where the PCT and Trust enter into a partnership arrangement where each pays half of some service or other, the organisation which holds clinical responsibility for the patients should report the total costs and activity, and the other organisation should not report anything for this service.

- E.g. If a service costs £10m in total, for scanning for 10,000 patients, for whom the PCT are clinically responsible, and the Trust incurs costs of £1m in providing the service, [which the PCT does not reimburse the Trust for,] then the PCT needs to report the unit cost as being £10m/10,000 = £1,000 / scan, and the Trust reports nothing. Although this will not be the way that the expenditure is reported in final accounts, Reference Costs only have to reconcile to final accounts figures, not balance exactly. Of course, this only works if the PCT agree to 'take' the £1m from the Trust for Reference Costs reporting purposes.

⇨ However, if the PCT do not, they will be artificially lowering the unit cost of the scan, and not reporting using full absorption costing, which contravenes the principles as laid out in the NHS Costing Manual.

Outpatients

⇨ **Outpatient Attendances: Consultant and Nursing Activity**

- As a general principle, the same patient should not be counted twice for attending the same clinic at the same time.

- Where nurses / technicians are providing support to a consultant, in a single clinic, and where the patient only has a single appointment for a specific clinic, we would not expect such activity to be counted as a separate and distinct attendance for Reference Costs outpatient clinic activity.

- Where a patient has two booked appointments, e.g. with a consultant and with a nurse, this should be counted as two attendances, where the attendances are for two discrete clinics, even if they're on the same day / in the same general location.

Clinical Trials

⇨ If the impact of income for clinical trials is such that to net it off would produce unrealistically low, zero or negative costs (i.e. surplus income), the costs and activity relating to such trials must be excluded).

Clinical trial costs and activity should only be included where the costs incurred are an accurate indication of what the actual costs of that treatment would be, outside the clinical trial setting.

ANNEX A – Admitted Patient Care Treatment Function Codes

For the 2010-11 collection, NHS organisations should report data for the following Treatment Function Codes:

Please note any Treatment Function Code shown below with an asterisk is not reported on the admitted patient care sheets – see the comment column for further details,

Code	Name	NHS Connecting for Health Description	Additional DH comment for Reference Cost reporting purposes
Surgical Specialties			
100	GENERAL SURGERY	Includes sub-categories not elsewhere listed eg endocrine surgery.	
101	UROLOGY		
102	TRANSPLANTATION SURGERY	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts.	
103	BREAST SURGERY	Includes treatment for cancer, suspected neoplasms, cysts and post-cancer reconstructive surgery. Excludes cosmetic surgery.	
104	COLORECTAL SURGERY	Surgical treatment of disorders of the lower intestine (colon, anus and rectum)	
105	HEPATOBILIARY & PANCREATIC SURGERY	Includes liver surgery, but liver transplantation should be recorded in 102 Transplantation Surgery	
106	UPPER GASTROINTESTINAL SURGERY		
107	VASCULAR SURGERY		
110	TRAUMA & ORTHOPAEDICS		
120	ENT	Ear, nose and throat	
130	OPHTHALMOLOGY		
140	ORAL SURGERY		
141	RESTORATIVE DENTISTRY	Endodontics, Periodontics and Prosthodontics are all part of Restorative Dentistry	

142	PAEDIATRIC DENTISTRY		
143	ORTHODONTICS		
144	MAXILLO-FACIAL SURGERY	Mouth, jaw and face related surgery.	
150	NEUROSURGERY		
160	PLASTIC SURGERY		
161	BURNS CARE	To be used by recognised specialist units and associated outreach services only	
170	CARDIOTHORACIC SURGERY	Should only be used where there are no separate services for Cardiac Surgery and Thoracic Surgery	
171	PAEDIATRIC SURGERY	This is paediatric general surgery	
172	CARDIAC SURGERY		
173	THORACIC SURGERY		
174	CARDIOTHORACIC TRANSPLANTATION	To be used by recognised specialist units and associated outreach services only. Includes pre- and post-operative services.	
180	ACCIDENT & EMERGENCY		
190	ANAESTHETICS *	Not a Treatment Function Code	This can be used in out-patients only. Pain Management should be recorded in 191.
191	PAIN MANAGEMENT	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team	
192	CRITICAL CARE MEDICINE *	Also known as Intensive Care Medicine.	Not reported as Inpatient/Day Case, see section 5

Medical Specialties			
211	PAEDIATRIC UROLOGY	Dedicated services to children with appropriate facilities and support staff	
212	PAEDIATRIC TRANSPLANTATION SURGERY	Dedicated services to children with appropriate facilities and support staff	
213	PAEDIATRIC GASTROINTESTINAL SURGERY	Dedicated services to children with appropriate facilities and support staff. Includes Upper Gastrointestinal Surgery and Colorectal Surgery.	
214	PAEDIATRIC TRAUMA AND ORTHOPAEDICS	Dedicated services to children with appropriate facilities and support staff.	
215	PAEDIATRIC EAR NOSE AND THROAT	Dedicated services to children with appropriate facilities and support staff	
216	PAEDIATRIC OPHTHALMOLOGY	Dedicated services to children with appropriate facilities and support staff	
217	PAEDIATRIC MAXILLO-FACIAL SURGERY	Dedicated services to children with appropriate facilities and support staff	
218	PAEDIATRIC NEUROSURGERY	Dedicated services to children with appropriate facilities and support staff	
219	PAEDIATRIC PLASTIC SURGERY	Dedicated services to children with appropriate facilities and support staff	
220	PAEDIATRIC BURNS CARE	Dedicated services to children with appropriate facilities and support staff	
221	PAEDIATRIC CARDIAC SURGERY	Dedicated services to children with appropriate facilities and support staff	
222	PAEDIATRIC THORACIC SURGERY	Dedicated services to children with appropriate facilities and support staff	
241	PAEDIATRIC PAIN MANAGEMENT	Dedicated services to children with appropriate facilities and support staff	

251	PAEDIATRIC GASTROENTEROLOGY	Dedicated services to children with appropriate facilities and support staff	
252	PAEDIATRIC ENDOCRINOLOGY	Dedicated services to children with appropriate facilities and support staff	
253	PAEDIATRIC CLINICAL HAEMATOLOGY	Dedicated services to children with appropriate facilities and support staff	
254	PAEDIATRIC AUDIOLOGICAL MEDICINE	Dedicated services to children with appropriate facilities and support staff	
255	PAEDIATRIC CLINICAL IMMUNOLOGY AND ALLERGY	Dedicated services to children with appropriate facilities and support staff	
256	PAEDIATRIC INFECTIOUS DISEASES	Dedicated services to children with appropriate facilities and support staff	
257	PAEDIATRIC DERMATOLOGY	Dedicated services to children with appropriate facilities and support staff	
258	PAEDIATRIC RESPIRATORY MEDICINE	Dedicated services to children with appropriate facilities and support staff	
259	PAEDIATRIC NEPHROLOGY	Dedicated services to children with appropriate facilities and support staff	
260	PAEDIATRIC MEDICAL ONCOLOGY	Dedicated services to children with appropriate facilities and support staff	
261	PAEDIATRIC METABOLIC DISEASE	Dedicated services to children with appropriate facilities and support staff	
262	PAEDIATRIC RHEUMATOLOGY	Dedicated services to children with appropriate facilities and support staff	

280	PAEDIATRIC INTERVENTIONAL RADIOLOGY	Dedicated services to children with appropriate facilities and support staff	
290	COMMUNITY PAEDIATRICS *	Includes routine health surveillance, health promotion, behavioural paediatrics and looked-after children. Excludes Paediatric Neuro-Disability.	Activity in this TFC should be reported in Community Care return (see section 6)
291	PAEDIATRIC NEURO-DISABILITY *	Dedicated services for children with Cerebral Palsy and non-progressive handicapping neurological conditions, with or without learning disability.	Please note, Learning Disability remains excluded from the Reference Costs collection
300	GENERAL MEDICINE	Includes sub-categories not elsewhere listed eg metabolic medicine.	
301	GASTROENTEROLOGY		
302	ENDOCRINOLOGY		
303	CLINICAL HAEMATOLOGY	Excludes ANTICOAGULANT SERVICE see 324	
304	CLINICAL PHYSIOLOGY	Physiological measurement including ECG (e.g. exercise testing, stress testing), gastrointestinal physiology, cardiac physiology, vascular technology, urodynamics, abd ophthalmic and vision science. Does not include Clinical Neurophysiology, Audiology or Respiratory Physiology.	
305	CLINICAL PHARMACOLOGY		
306	HEPATOLOGY	Also known as liver medicine	
307	DIABETIC MEDICINE		
308	BLOOD AND MARROW TRANSPLANTATION	Previously in Clinical Haematology. Includes haemopoietic stem cell transplantation.	Previously (in 2005/06) collected in specialist services – now collected in the Elective/Non Elective/ Day Case return, using HRG4
309	HAEMOPHILIA	Previously in Clinical Haematology	
310	AUDIOLOGICAL MEDICINE	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication.	Excludes audiology and hearing tests. (see section 10 for more detail)

311	CLINICAL GENETICS	To be used by recognised specialist units and associated outreach services only.	
312	CLINICAL CYTOGENETICS and MOLECULAR GENETICS	Not a Treatment Function	Retained for consistency with previous reference costs collections
313	CLINICAL IMMUNOLOGY and ALLERGY	Should only be used where there are no separate services for Clinical Immunology and Allergy	
314	REHABILITATION *		Please see section 8 for information about costs and activity being separately identified.
315	PALLIATIVE MEDICINE		
316	CLINICAL IMMUNOLOGY		
317	ALLERGY	The diagnosis and management of allergic disease (abnormal immune responses to external substances) and the exclusion of allergic causes in other conditions.	
318	INTERMEDIATE CARE *	Intermediate care encompasses a range of multi-disciplinary services designed to safeguard independence by maximising rehabilitation and recovery after illness or injury	Excluded from Reference Costs
319	RESPITE CARE		
320	CARDIOLOGY		
321	PAEDIATRIC CARDIOLOGY		
322	CLINICAL MICROBIOLOGY		
323	SPINAL INJURIES	To be used by recognised specialist units and associated outreach services only.	
324	ANTICOAGULANT SERVICE *	The monitoring and control of anticoagulant therapy including the initiation and/or supervision of oral anticoagulant therapy and the determination of anticoagulant dosage.	This can be used in out-patients only.
330	DERMATOLOGY		
340	RESPIRATORY MEDICINE	Also known as Thoracic Medicine	
341	RESPIRATORY PHYSIOLOGY	Physiological measurement of the function of the respiratory system. Includes Sleep Studies (the diagnosis and treatment of sleep disordered breathing, including upper airway resistance syndrome and sleep apnoea).	
350	INFECTIOUS DISEASES		

352	TROPICAL MEDICINE		
360	GENITO-URINARY MEDICINE		
361	NEPHROLOGY		
370	MEDICAL ONCOLOGY	The diagnosis and treatment, typically with chemotherapy, of patients with cancer.	
371	NUCLEAR MEDICINE		
400	NEUROLOGY		
401	CLINICAL NEURO-PHYSIOLOGY	The study of the central and peripheral nervous systems through the recording of bioelectrical activity. Includes EEG.	
410	RHEUMATOLOGY		
420	PAEDIATRICS		
421	PAEDIATRIC NEUROLOGY		
422	NEONATOLOGY *	Special Care, High Dependency and Intensive Care	see section 5 for specialist services
424	WELL BABIES *	Care given by the mother/substitute with medical and neonatal nursing advice if needed	Activity Excluded from Reference Costs Collection – Costs should be reported as part of the delivery episode
430	GERIATRIC MEDICINE		
450	DENTAL MEDICINE SPECIALTIES	Includes oral medicine.	
460	MEDICAL OPHTHALMOLOGY		
501	OBSTETRICS	The management of pregnancy and childbirth including miscarriages but excluding planned terminations.	
502	GYNAECOLOGY	Disorders of the female reproductive system. Includes planned terminations.	
503	GYNAECOLOGICAL ONCOLOGY		
560	MIDWIFE EPISODE		
653	PODIATRY	To include Podiatric Surgery where necessary	
840	AUDIOLOGY *	Physiological measurement and diagnosis of hearing disorders, and the rehabilitation of patients with hearing loss.	See section 10

800	CLINICAL ONCOLOGY (previously RADIOTHERAPY)	The diagnosis and treatment, typically with radiotherapy, of patients with cancer.	Retained as Clinical Oncologists do more than just Radiotherapy. However, please see sections 8 for information about radiotherapy costs and activity being separately identified.
Radiology			
280	PAEDIATRIC INTERVENTIONAL RADIOLOGY	Dedicated services to children with appropriate facilities and support staff	
810	RADIOLOGY *	Not a Treatment Function Code	
811	INTERVENTIONAL RADIOLOGY *		Not to be used for Diagnostic Imaging.
812	DIAGNOSTIC IMAGING *	The production and interpretation of high quality images of the body to diagnose injuries and disease, e.g. x-rays, ultrasound, MRI, PET or CT scans.	Please see section 8 for information about costs and activity being separately identified.
DAPF	DIRECT ACCESS PLAIN FILM	Not a treatment function code	
Pathology			
822	CHEMICAL PATHOLOGY	Can be a support service. Reported as composite HRG unless Direct Access where activity and costs should be separately identified.	Please see section 9
Other			
242	PAEDIATRIC INTENSIVE CARE	Only to be used by designated Paediatric Intensive Care Units	
999	GLOBAL TRUST COSTS	Not a Treatment Function	Applicable to Reference Costs only

Some NHS organisations have opted to report procedure and treatments on an organisational wide, rather than Treatment Function specific, basis. In this situation, costs and activity should be reported using Treatment Function 999, which has been retained for 2010-11. However, organisations should make every attempt to report using the relevant Treatment Function Code Groups.

ANNEX B – Devices Required For Reference Costs

For tariff development purposes, please provide (where appropriate) the total cost of the devices listed below within Statement Z in the Reference Cost return.

Please note, where a device is listed as 'Added/Amended in 2011/12' this refers to changes that have been made to this list since the 2010/11 device exclusion list, as such they should be excluded from the reference costs collection for 10/11.

Devices:	Note	Statement Z
3 dimensional mapping and linear ablation catheters used for complex cardiac ablation procedures	Added/amended in 2011/12	Include total cost of device
Aneurysm coils		Include total cost of device
Artificial Urinary Sphincter	New specific HRG LB50Z Implantation of Artificial Urinary Sphincter - Male and Female	Include total cost of device
Bespoke orthopaedic prostheses[6]		Include total cost of device
Bone Anchored Hearing Aids	Specific HRGs CZ27Z Fixture of Bone Anchored Hearing Aids and CZ28Z Fitting of Bone Anchored Hearing Aids	Include total cost of device
Bone Growth Stimulators		Include total cost of device
Carotid, iliac and renal stents[7]		Include total cost of device
Circular external fixator frame	Added/amended in 2011/12	Include total cost of device
Consumables associated with per oral/per anal single operator cholangioscope		Include total cost of device
Consumables for robotic surgery		Include total cost of device
Deep brain, vagal, sacral, spinal cord and occipital nerve stimulators	New specific HRG AB07Z Insertion of neurostimulator or intrathecal drug delivery device	Include total cost of device
Devices used in connection with pulmonary artery banding		Include total cost of device
Drug-eluting peripheral angioplasty balloon		Include total cost of device
Endovascular stent graft		Include total cost of device
ICD (Implantable Cardioverter-Defibrilator)		Include total cost of device
ICD with CRT (Cardiac Resynchronisation Therapy) capability		Include total cost of device
Insulin pumps and pump consumables		Include total cost of device
Intracranial stents		Include total cost of device
Intrathecal drug delivery pumps		Include total cost of device
Laser Sheaths	Added/amended in 2011/12	Include total cost of device

[6] Bespoke prostheses designed and manufactured for individual patients plus modular limb salvage replacements for femur or shoulder (non CE marked)
[7] Includes embolic protection devices

Maxillofacial bespoke prostheses		Include total cost of device
Occluder vascular and septal devices		Include total cost of device
Penile prosthesis		Include total cost of device
Percutaneous valve replacement devices	There are now specific HRGs for valve replacements	Include total cost of device
Peripheral vascular stents		Include total cost of device
Radiofrequency ablation probes[8]	Added/amended in 2011/12	Include total cost of device
Video Capsule for Endoscopy	Removed from exclusion list for 2011/12 – Now FZ42Z	N/A
Ventricular Assist devices (VAD)	There are now specific HRG EA43Z Implantation of Prosthetic Heart or Ventricular Assist Device	Include total cost of device

Within the table above there are a number of HRGs where the device is identified as part of the procedure, however the costs of the device still need to separately identify as costs for the HRG would include other costs associated with the procedure.

[8] When used for treating tumours

ANNEX C – Outpatient Treatment Function Codes

For the 2010-11 collection, consistent with previous years, the majority of Outpatient attendance/Contact data is no longer split by adult/child. Paediatric Treatment Function codes have been developed to identify the differences in service provision for children. The categories (Physiotherapy, Occupational Therapy, Speech, Cystic Fibrosis and Dietetics) still requiring the age split are shown with an asterisk (*) below.

Where appropriate, updated Treatment Function Codes, per those issued in DSCN 02/2007 (effective from 1st October 2007) have been utilised. In addition, specified sub-specialties have been retained for the Reference Costs 2010-11 collection. Please note that for the 2010-11 collection, Outpatient Maternity and Obstetrics data should continue to be reported within the outpatient section of the collection files. These are no longer required split by Diabetes, High Risk, Substance Misuse and other High Risk (see section 11).

Code	Treatment Function Title	Comment for Ref Costs reporting
100	General Surgery	
101	Urology	
102	Transplantation Surgery	
103	Breast Surgery	
104	Colorectal Surgery	
105	Hepatobiliary & Pancreatic Surgery	
106	Upper Gastrointestinal Surgery	
107	Vascular Surgery	
110n	Trauma & Orthopaedics: Non-Trauma	TFC split for Ref Costs reporting purposes
110t	Trauma & Orthopaedics: Trauma	as above
120	ENT	
130	Ophthalmology	
140	Oral Surgery	
141	Restorative Dentistry	
142	Paediatric Dentistry	
143	Orthodontics	
144	Maxillo-Facial Surgery	
150	Neurosurgery	
160	Plastic Surgery	
161	Burns Care	To be used by recognised specialist services only
170	Cardiothoracic Surgery	
171	Paediatric Surgery	
172	Cardiac Surgery	
173	Thoracic Surgery	
174	Cardiothoracic Transplantation	To be used by recognised specialist services only
180	Accident & Emergency	
190	Anaesthetics	Not a Treatment Function – used for Outpatient Reference Cost reporting purposes
191	Pain Management	
192	Critical Care Medicine	
211	Paediatric Urology	
212	Paediatric Transplantation Surgery	
213	Paediatric Gastrointestinal Surgery	
214	Paediatric Trauma And Orthopaedics	
215	Paediatric Ear Nose And Throat	
216	Paediatric Ophthalmology	
217	Paediatric Maxillo-Facial Surgery	
218	Paediatric Neurosurgery	
219	Paediatric Plastic Surgery	

220	Paediatric Burns Care	
221	Paediatric Cardiac Surgery	
222	Paediatric Thoracic Surgery	
241	Paediatric Pain Management	
242	Paediatric Intensive Care	
251	Paediatric Gastroenterology	
252	Paediatric Endocrinology	
253	Paediatric Clinical Haematology	
254	Paediatric Audiological Medicine	
255	Paediatric Clinical Immunology and Allergy	
256	Paediatric Infectious Diseases	
257	Paediatric Dermatology	
258	Paediatric Respiratory Medicine	
259	Paediatric Nephrology	
260	Paediatric Medical Oncology	
261	Paediatric Metabolic Disease	
262	Paediatric Rheumatology	
280	Paediatric Interventional Radiology	
290	Community Paediatrics	Do not report OP activity in this TFC. For Reference Cost purposes, report costs/activity as Community (see section 6).
291	Paediatric Neuro-Disability-	Reference Cost reporting should include all 'neurodevelopmental' conditions
300	General Medicine	
301m	Medical Gastroenterology	TFC split for Ref Costs reporting purposes
301s	Surgical Gastroenterology	TFC split for Ref Costs reporting purposes
302	Endocrinology	TFC split for Ref Costs reporting purposes
302s	Endocrine Surgery	TFC split for Ref Costs reporting purposes
303	Clinical Haematology	
304	Clinical Physiology	
305	Clinical Pharmacology	
306	Hepatology	
307	Diabetic Medicine	
BMTPT	Bone Marrow Transplant- Post Transplantation	TFC split for Ref Costs reporting purposes
BMTO	Bone Marrow Transplant- Other	TFC split for Ref Costs reporting purposes
309	Haemophilia	
310	Audiological Medicine	
311	Clinical Genetics	
312	Clinical Cytogenetics and Molecular Genetics	Not a Treatment Function
313	Clinical Immunology & Allergy	
314	Rehabilitation	
315	Palliative Medicine	
316	Clinical Immunology	
317	Allergy	
319	Respite Care	
320	Cardiology	
321	Paediatric Cardiology	
322	Clinical Microbiology	
323	Spinal Injuries	Specialist units only
324	Anticoagulant Service	
330	Dermatology	
340	Respitory Medicine	Also known as Thoracic Medicine
341	Respiratory Physiology	
350	Infectious Diseases	
352	Tropical Medicine	

360	Genito-Urinary Medicine	
361	Nephrology	
370	Medical Oncology (Attendance Without Treatment)	
CMDT_C	Colorectal MDT meetings	Not a TFC – used for Outpatient Reference Cost reporting purposes see page 29-31
CMDT_LG	Local Gynae MDT meetings	As above
CMDT_SpG	Specialist Gynae MDT meetings	As above
CMDT_B	Breast MDT meetings	As above
CMDT_SpU	Specialist UGI meetings	As above
TCMDT_C	Total Cost Colorectal MDT meetings	As above
TCMDT_LG	Total Cost Local Gynae MDT meetings	As above
TCMDT_SpG	Total Cost Specialist Gynae MDT meetings	As above
TCMDT_B	Total Cost Breast MDT meetings	As above
TCMDT_SpU	Total Cost Specialist UGI meetings	As above
TMCDT	Total Cost Cancer Multi-Disciplinary	As above
371	Nuclear Medicine	
400	Neurology	
401	Clinical Neuro-Physiology	
410	Rheumatology	
420	Paediatrics	
421	Paediatric Neurology	
422	Neonatology	see section 5
430	Geriatric Medicine	
450	Dental Medicine Specialties	
460	Medical Ophthalmology	
501	Obstetrics	
501OU	Ante-Natal Ultrasound	Not a TFC – used for Outpatient Reference Cost reporting purposes
502	Gynaecology	
503	Gynaecological Oncology	
560	Midwife Episode	
650	Physiotherapy*	TFC split by age for Ref Costs reporting purposes
651	Occupational Therapy*	as above
652	Speech & Language Therapy*	as above
653	Podiatry	
654	Dietetics*	TFC split by age for Ref Costs reporting purposes
655	Orthoptics	
800	Clinical Oncology (Without Treatment)	
812	Diagnostic Imaging	Diagnostic Imaging is separately identified – see section 8
821	Blood Transfusion	
822	Chemical Pathology	
840	Audiology	see section 10 for Reference Cost definitions on what to report as Outpatient and what to include in Audiology Services
CSB1	Cystic Fibrosis - Band 1*	Not a TFC – for Reference cost purposes only – see guidance on pages 27-28
CSB2	Cystic Fibrosis - Band 2*	as above
CSBA	Cystic Fibrosis - All Other Bands*	as above
FPC	Sexual and Reproductive Health Clinic (previously referred to as	as above

	Family Planning Clinic)	
DAPF	Direct Access Plain Film	Not a TFC – applicable for Reference Costs only to support Diagnostic Imaging collection
H/A	HIV/ AIDS	
AuS	Audiological Services	separate collection – please see Audiology
999	Other	Not a TFC – applicable for Reference Costs only

ANNEX D – High Cost Drugs / OPCS Mapping

The mapping from high cost drug to OPCS-4.5 code to HRG is no longer contained in this guidance. Annex E lists all high cost drugs with their respective OPCS codes, which can be linked to an HRG using the Code to Group tab in the 'Code to Group

Please note that this document is a component of the HRG4 2010-11 Reference Costs Grouper suite of supporting documents and as such will not be available until release of the Grouper, which is scheduled for April 2011. At this time the 2010-11 Grouper and supporting documentation will become available at the following link:

http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads

Please refer to NHS Connecting for Health for the latest information regarding coding of High Cost Drugs.

As NHS Connecting for Health coding guidance states that the .8 and .9 subcategories must not be used for High Cost Drug categories, HRGs XD35Z and XD36Z have been removed from the Reference Cost collection since 2008/09.

ANNEX E – Clarification of reporting of ALL HCDs – (HRGs and/or Statement Z?)

The costs of those drugs (e.g. Alitretinoin) that are not unbundled in 2010-11, but that are on the tariff exclusion list should be included in the core HRG costs, however, these should also be reported as a **quantum of costs** within statement Z as a memorandum item. This is to enable further tariff development in this area.

To clarify, in the 2010-11 Reference Cost collection please report the High Cost Drugs as follows:

Drug Name	OPCS Coded and/or Statement Z?
Abacavir	X866
Abatacept	X921
Adalimumab	X921
Adefovir	X863
Agalsidase alfa	X914
Agalsidase beta	X914
Aldesleukin	X893
Alemtuzumab	X891
Alglucosidase alfa	X914
Alitretinoin	Statement Z
Alteplase	X833
Ambrisentan	X821
Amifampridine phosphate	Statement Z
Amphotericin liposomal	X861
Amprenavir	X866 + Statement Z
Anakinra	X921
Anidulafungin	X861
Antihaemophilic Factor/von Willebrand Factor Complex (haemate)	X831
Antilymphocyte globulin	X902
Antithymocyte Immunoglobulin	X902
Antithrombin III	X831
Atazanavir	X866
Azacitadine	X891
Basiliximab	X892
Beractant	X842
Betaine	X913
Bevacizumab	X931
Boceprevir	Statement Z
Bortezomib	X891
Bosentan	X822
Botulinum toxin	X851
C1 Esterase inhibitor (also known as C1-inhibitors)	X891
Carglumic acid	X913
Carnitine	X914
Caspofungin	X861
Certolizumab Pegol	X921
Cetuximab	X891
Cidofovir	X867
Cladribine	X893
Co-careldopa internal tube intestinal gel	X891
Daclizumab	X892 + Statement Z

Darbopoetin alfa	Statement Z
Darunavir	X866
Dasatinib	X906
Decitabine	Statement Z
Deferasirox (For chronic iron overload)	X902
Deferiprone (For chronic iron overload)	X902
Denosumab	X873 + Statement Z
Desferrioxamine (For chronic iron overload)	X902
Dexamethasone intravitreal implant	Statement Z
Dibotermin alfa	X923
Didanosine	X866
Dornase alfa	X843
Drotrecogin alfa	X832
Eculizumab	X902
Efavirenz	X866
Eltrombopag	X905
Emtricitabine	X866
Enfuvirtide	X866
Entecavir	X863
Epoetin alfa	Statement Z
Epoetin beta	Statement Z
Epoetin zeta	Statement Z
Epoprostenol	X824
Eptotermin alfa	X923
Erlotinib	X906
Etanercept	X921
Etravirine	X866
Everolimus	Statement Z
Factor IX	X831
Factor VII	X831
Factor VIIa (Eptacog alfa)	X831
Factor VIII	X831
Factor VIII inhibitor bypassing factor	X831
Factor XIII	X831
Fampridine	Statement Z
Fibrin sealants	X831
Fibrinogen	X831
Fingolimod	Statement Z
Filgrastim	X903
Flebogamma	X961
Fomepizole	X891
Fosamprenavir	X866
Foscarnet	X867
Galsulfase	X914
Gammagard	X961
Gammaplex	Statement Z
Ganciclovir	X867
Gefitinib	Statement Z
Glatiramer	X893
Golimumab	X921
Human Arginate	X914
Icatibant	X891

Idursulfase	X914
Iloprost	X823
Imatinib	X906
Imiglucerase	X914
Immunoglobulin	X961
Indinavir	X866
Infliximab	X921
Interferon alfa	X863
Interferon Beta	X893
Intratect	X961
Kiovig	X961
Lamivudine	X866
Lanreotide	X894
Lapatinib	X906
Laronidase	X914
Lenalidomide	X893
Lenograstim	X903
Lopinavir with Ritonavir	X866
Maraviroc	X866
Mecasermin	X872
Mercaptamine	X911
Micafungin	X861
Miglustat	X913
Motavizumab	X865
Natalizumab	X893
Nelfinavir	X866
Nevirapine	X866
Nilotinib	X906
Nitisinone	X911
Nitric Oxide	X841
Octagam	X961
Octreotide	X894
Omalizumab	X892
Palivizumab	X865
Parathyroid hormone	X873
Parenteral Nutrition	X904
Peg interferon alfa	X864
Pegaptanib	X931
Pegfilgrastim	X903
Pegvisomant	X871
Pirfenidone	Statement Z
Plerixafor	X891
Poractant alfa	X842
Porcine Factor	X831
Posaconazole	X861
Privigen	X961
Protein C	X831
Prothrombin Complex	X831
Raltegravir	X866
Ranibizumab	X931
Rasburicase	X922
Ribavirin	X864

Rilpivirine	Statement Z
Riluzole	X852
Riociguat	Statement Z
Ritonavir	X866
Rituximab	X892
Romiplostim	X905
Sandoglobulin	X961
Sapropterin	X914
Saquinavir	X866
Sildenafil (only when used for PPH)	X821
Sitaxentan	X822
Sodium oxybate	X853
Sodium phenylbutyrate	X912
Somatropin	X872
Sorafenib	X906
Stavudine	X866
Subcuvia	X961
Subgam	X961
Sunitinib	X906
Tadalafil (only when used for PPH)	X821
Telaprevir	Statement Z
Telbivudine	X863
Temsirolimus	X906
Tesamorelin	X872
Tenofovir	X866
Tenofovir with Emtricitabine	X866
Tenofovir with Emtricitabine and Efavirenz	X866
Teriparatide	X873
Tetrahydrobiopterin	X913
Thalidomide	X893
Thrombin	X831
Tipranavir	X866
Tocilizumab	X921
Tolvaptan	X891
Valganciclovir	X867
Ustekinumab	X891
Vicriviroc	Statement Z
Vigam	X961
Vivaglobin	X961
Voriconazole	X862
Zalcitabine	X866 + Statement Z
Ziconotide	X854
Zidovudine	X866
Zidovudine with Lamivudine	X866
Zidovudine with Lamivudine and Abacavir	X866

ANNEX F - Rehabilitation OPCS 4.5 codes

Derivation of rehabilitation HRGs is dependent on the recording of rehabilitation activity using one of the following OPCS codes:

OPCS Code	Label
U501	Delivery of rehabilitation for amputation of limb
U502	Delivery of rehabilitation for hip fracture
U503	Delivery of rehabilitation for joint replacement
U504	Delivery of rehabilitation for rheumatoid arthritis
U505	Delivery of rehabilitation for osteoarthritis
U508	Other specified rehabilitation for musculoskeletal disorders
U509	Unspecified rehabilitation for musculoskeletal disorders
U511	Delivery of rehabilitation for brain injuries
U512	Delivery of rehabilitation for spinal cord injury
U513	Delivery of rehabilitation for pain syndromes
U518	Other specified rehabilitation for neurological disorders
U519	Unspecified rehabilitation for neurological disorders
U521	Delivery of rehabilitation for drug addiction
U522	Delivery of rehabilitation for alcohol addiction
U528	Other specified rehabilitation for psychiatric disorders
U529	Unspecified rehabilitation for psychiatric disorders
U531	Delivery of rehabilitation following plastic maxillofacial reconstructive surgery
U532	Delivery of rehabilitation following other plastic reconstructive surgery NEC
U533	Delivery of rehabilitation for burns
U534	Delivery of rehabilitation for trauma NEC
U538	Other specified rehabilitation for trauma and reconstructive surgery
U539	Unspecified rehabilitation for trauma and reconstructive surgery
U541	Delivery of rehabilitation for acute cardiac disorders
U542	Delivery of rehabilitation for respiratory disorders
U543	Delivery of rehabilitation for stroke
U548	Other specified rehabilitation for other disorders
U549	Unspecified rehabilitation for other disoders
X601	Rehab. Assessment by multidisciplinary, non-specialised team
X602	Rehab. Assessment by multidisciplinary, specialised team
X603	Rehab. Assessment by unidisciplinary team
X608	Other specified rehabilitation assessment
X609	Unspecified rehabilitation assessment

Please note that this table has been taken from the NHS Information Centre website, which should always be checked to ensure that this remains the latest version.

Annex G – Paramedic Services Call Categorisation

Classification Narrative	Cat. A/ Red	Cat. B/ Amber	Cat. C/ Green	MPDS Versions 10 & 11 Code Prefix	CBD HRG4 Code Prefix
▪ 01 Abdominal Pain/Problems; Abdominal / Back Pain	✓	✓	✓	1***	01***
▪ 02 Allergies (reactions)/ Envenomations (stings, bites); Allergic Reaction	✓	✓	✓	2***	02***
▪ 03 Animal Bites/ Attacks	✓	✓	✓	3***	03***
▪ 04 Assault/ Sexual Assault/ Rape; Assault / Trauma	✓	✓	✓	4***	21***
▪ 05 Back Pain (incl. non traumatic)	✓	✓	✓	5***	N/A
▪ 06 Breathing Problems; Breathing Difficulty	✓	✓	✓	6***	05***
▪ 07 Burns/ Explosion	✓	✓	✓	7***	22***
▪ 08 Carbon Monoxide/ Inhalation/ Hazardous Chemical; Environmental Emergency	✓	✓	N/A	8***	10***
▪ 09 Cardiac or Respiratory Arrest/ Death	✓	✓	N/A	9***	06***
▪ 10 Chest Pain	✓	✓	✓	10***	07***
▪ 11 Choking	✓	✓	✓	11***	08***
▪ 12 Convulsions/ Fitting	✓	✓	N/A	12***	11***
▪ 13 Diabetic Problems	✓	✓	✓	13***	09***
▪ 14 Drowning (incl. near)/ Diving/ SCUBA Accident	✓	✓	N/A	14***	23***
▪ 15 Electrocution/ Lightning	✓	✓	N/A	15***	N/A
▪ 16 Eye Problems	✓	✓	✓	16***	N/A
▪ 17 Falls/ Back Injuries (traumatic); Falls/ Accidents	✓	✓	✓	17***	24***
▪ 18 Headache	✓	✓	✓	18***	13*** 25***
▪ 19 Heart Problems/ A.I.C.D.	✓	✓	✓	19***	N/A
▪ 20 Heat / Cold Exposure	✓	✓	✓	20***	N/A
▪ 21 Haemorrhage/ Lacerations; Bleeding	✓	✓	✓	21***	04***
▪ 22 Industrial/ Machinery Accidents	✓	✓	N/A	22***	N/A
▪ 23 Overdose/ Poisoning/ Ingestion	✓	✓	N/A	23***	15***
▪ 24 Pregnancy/ Childbirth/ Miscarriage; Gynaecological	✓	✓	✓	24***	12*** 16***
▪ 25 Psychiatric/ Suicide Attempt; Mental/ Emotional	✓	✓	✓	25***	14***
▪ 26 Sick Person (Specific Diagnosis)	✓	✓	✓	26***	N/A
▪ 27 Stab/ Gunshot Wound	✓	✓	✓	27***	N/A
▪ 28 Stroke/ CVA	✓	✓	N/A	28***	18***
▪ 29 Traffic/ Transportation Accidents; RTAs	✓	✓	N/A	29***	26***
▪ 30 Traumatic Injuries (Specific)	✓	✓	✓	30***	N/A
▪ 31 Unconscious/ Fainting (near)/ Passing Out (non-traumatic)	✓	✓	✓	31***	19***
▪ 32 Unknown Problem (incl. collapse - 3rd party); Sick/ Unknown/ Other	✓	✓	✓	32***	17***

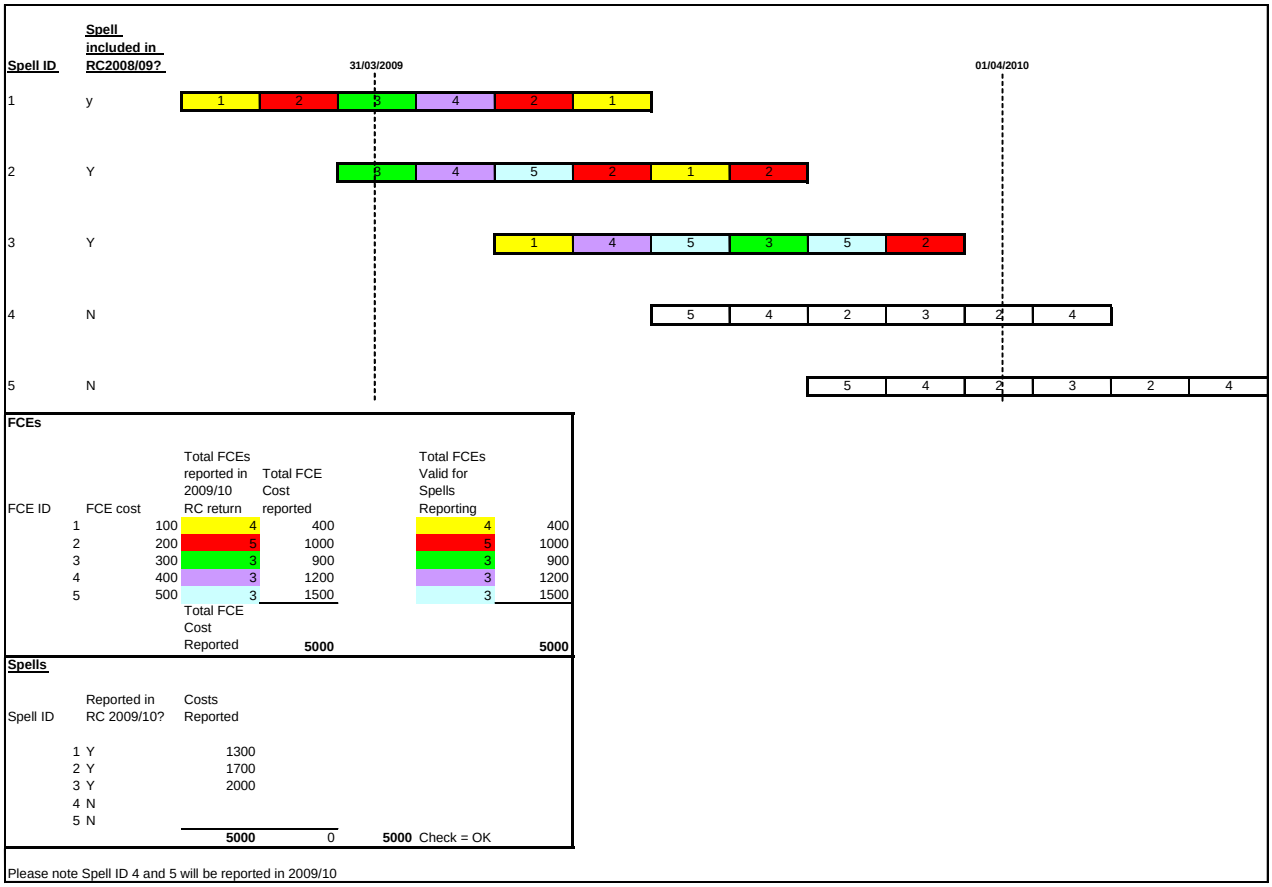
ANNEX H – Pre-processing and Post Processing required for Reference Costs activity data for 2010-11 collection

FCEs when they run over 2 collection periods.

Where a spell continues into the next reporting year, all associated FCEs should be excluded from this collection.

To illustrate this, a number of examples detailing different spells and the relevant treatment are detailed below. Spell IDs 1,2 and 3 all end in the current reporting year and therefore should be included in this collection. Spell IDs 4 and 5 continue into the next reporting year therefore should be excluded from the collection.

Diagram



Post Processing of Data

Totally Unbundled HRGs

The HRG4 2010-11 Reference Costs Grouper will unbundle any items from the 'main' HRG.
When a HRG is entirely made up of unbundled items, the Grouper will return an activity against HRG code ZZ01Z.

No costs should be reported against this HRG. The costs of this HRG will be reported, on a full absorption basis, within the unbundled HRGs.

Gateway Reference: 15289

Annex I - The following information should help NHS colleagues in costing the following HRGs for Kidney Transplants:

		2008/09 kidney transplant reference costs - Things to look out for		
HRG code	**HRG description**	**Elective**	**Non elective**	**Short stay non elective**
LA01A	Kidney Transplant from Cadaver non-Heart beating donor (recipient - 19 years and over)	Kidney transplants from cadaver donors should NOT take place as elective activity. There should **NOT** be **ANY** elective activity against this HRG - must be miscoded. **Transfer all activity recorded against this HRG to NON ELECTIVE**	Non elective kidney transplants are carried out from cadaver donors only. Therefore **Assume activity recorded against this HRG is correct.**	It is **very unlikely**1 that a kidney transplant episode length of stay can be less than 2 days. A transplant consultant should retain responsibility for the patient during surgery and post operative inpatient care. From a clinical perspective therefore, there should NOT be ANY short stay non elective activity against this HRG, however, it is recognised that different organisations have different protocols around coding data and therefore, **if you are confident that activity has been coded correctly (in conjuction with relevent clinicians), please leave this category within the ref cost return,** as it will highlight where there are differences between organisations relating to consultant transfer of responsibility (or coding issues) during the kidney transplant episode.This will need to be investigated and clarified at a national level.
LA01B	Kidney Transplant from Cadaver non-Heart beating donor (recipient - 18 years and under)	Kidney transplants from cadaver donors should NOT take place as elective activity. There should **NOT** be **ANY** elective activity against this HRG - must be miscoded. **Transfer all activity recorded against this HRG to NON ELECTIVE**	Non elective kidney transplants are carried out from cadaver donors only. Therefore **Assume activity recorded against this HRG is correct.**	See LA01A above...**if you are confident that activity has been coded correctly (in conjuction with relevent clinicians), please leave this category within the ref cost return,** as it will highlight where there are differences between organisations relating to consultant transfer of responsibility (or coding issues) during the kidney transplant episode.This will need to be investigated and clarified at a national level.
LA02A	Kidney Transplant from Cadaver Heart beating donor (recipient - 19 years and over)	Kidney transplants from cadaver donors should NOT take place as elective activity. There should **NOT** be **ANY** elective activity against this HRG - must be miscoded. **Transfer all activity recorded against this HRG to NON ELECTIVE**	Non elective kidney transplants are carried out from cadaver donors only. Therefore **Assume activity recorded against this HRG is correct.**	See LA01A above...**if you are confident that activity has been coded correctly (in conjuction with relevent clinicians), please leave this category within the ref cost return,** as it will highlight where there are differences between organisations relating to consultant transfer of responsibility (or coding issues) during the kidney transplant episode.This will need to be investigated and clarified at a national level.
LA02B	Kidney Transplant from Cadaver Heart beating donor (recipient - 18 years and under)	Kidney transplants from cadaver donors should NOT take place as elective activity. There should **NOT** be **ANY** elective activity against this HRG - must be miscoded. **Transfer all activity recorded against this HRG to NON ELECTIVE**	Non elective kidney transplants are carried out from cadaver donors only. Therefore **Assume activity recorded against this HRG is correct.**	See LA01A above...**if you are confident that activity has been coded correctly (in conjuction with relevent clinicians), please leave this category within the ref cost return,** as it will highlight where there are differences between organisations relating to consultant transfer of responsibility (or coding issues) during the kidney transplant episode.This will need to be investigated and clarified at a national level.
LA03A	Kidney Transplant from Live donor (recipient - 19 years and over)	Elective kidney transplants are carried out from live donors only. This is the ONLY HRG therefore, where elective activity should take place. **Assume activity recorded against this HRG is correct.**	Kidney transplants from live donor should NOT take place as non elective activity. There should **NOT** be **ANY** non elective activity against this HRG - must be miscoded. **Transfer all activity recorded against this HRG to ELECTIVE**	See LA01A above...**if you are confident that activity has been coded correctly (in conjuction with relevent clinicians), please leave this category within the ref cost return,** as it will highlight where there are differences between organisations relating to consultant transfer of responsibility (or coding issues) during the kidney transplant episode.This will need to be investigated and clarified at a national level.
LA03B	Kidney Transplant from Live donor (recipient - 18 years and under)	Elective kidney transplants are carried out from live donors only. This is the ONLY HRG therefore, where elective activity should take place. **Assume activity recorded against this HRG is correct.**	Kidney transplants from live donor should NOT take place as non elective activity. There should **NOT** be **ANY** non elective activity against this HRG - must be miscoded. **Transfer all activity recorded against this HRG to ELECTIVE**	See LA01A above...**if you are confident that activity has been coded correctly (in conjuction with relevent clinicians), please leave this category within the ref cost return,** as it will highlight where there are differences between organisations relating to consultant transfer of responsibility (or coding issues) during the kidney transplant episode.This will need to be investigated and clarified at a national level.

Our thanks go to the 'Kidney Transplant Project' on behalf of 'NHS Kidneycare', who provided the information.