



Department  
of Health

# Reference costs guidance 2014-15

February 2015

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# Section 1: Introduction

## Purpose and context

1. This guidance forms chapter 3 of Monitor's *Approved Costing Guidance 2014-15*<sup>1</sup>.
2. Trusts should read all sections of the guidance, and complete all reporting lines in the collection templates, that are relevant to the services they provide, regardless of their trust type. Table 1 provides a guide.

**Table 1: Intended users**

Section	Contents	Acute	Mental health	Community	Ambulance
1	<b>Introduction</b> Essential information to help trusts prepare for the 2014-15 collection.	✓	✓	✓	✓
2	<b>Data quality, validation and assurance</b> Required reading for all trusts	✓	✓	✓	✓
3	<b>Admitted patient care</b>	✓	✓	✓	
4	<b>Outpatient services</b>	✓	✓	✓	
5	<b>Emergency medicine</b>	✓	✓	✓	
6	<b>Unbundled services</b>	✓	✓	✓	
7	<b>Renal dialysis</b>	✓			
8	<b>Direct access services</b>	✓	✓	✓	
9	<b>Mental health services</b>	✓	✓	✓	
10	<b>Community services</b>	✓	✓	✓	
11	<b>Ambulance services</b>				✓
12	<b>Cystic fibrosis</b>	✓			
13	<b>Services excluded from reference costs</b> Required reading for all trusts.	✓	✓	✓	✓
14	<b>Reconciliation</b> Essential information about reconciling reference costs to the final signed accounts. Required reading for all trusts.	✓	✓	✓	✓

## Essential resources

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

**Unify2**<sup>2</sup> – the Department's corporate data collection system

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

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

<sup>1</sup> <https://www.gov.uk/government/publications/approved-costing-guidance>

<sup>2</sup> <http://nww.unify2.dh.nhs.uk/Unify2/interface/homepage.aspx>

- a **spells workbook** for reporting spell unit costs and activity. We refer to this workbook as **SPELLS**

**Reference costs system and workbook user guide** – a manual to help users submit their data in Unify2, which we will make available in the Unify2 forum in April

**Healthcare Resource Group 4+ (HRG4+) 2014-15 Reference Costs Grouper and documentation**<sup>3</sup> - The National Casemix Office (NCO)<sup>4</sup> at the Health and Social Care Information Centre (HSCIC) publish the Grouper and supporting documentation including user manual, the Code to Group, individual chapter summaries, and a high level summary of changes from the previous costing Grouper release<sup>5</sup>

The NCO has also provided us with an early view of the key changes to the grouper this year, it can be found in [Annex E](#). Full details of the design changes will be available alongside the grouper when it is released.

The **Terminology Reference-data Update Distribution (TRUD)** service<sup>6</sup> supply a number of data sets (that are also available on the Unify2 forum) to support consistent coding of activity, including:

- the **chemotherapy regimens list**, including adult and paediatric regimens, with mapping to OPCS-4 codes that have one-to-one relationships with unbundled chemotherapy HRGs
- the National Interim Clinical Imaging Procedure (NICIP) code set of **clinical imaging procedures**<sup>7</sup>, with mapping to OPCS-4 codes that relate to unbundled diagnostic imaging HRGs
- the **high cost drugs list** and map to OPCS-4 codes
- the National Laboratory Medicines Catalogue, a national catalogue of **pathology tests**

**Patient level information and costing systems and reference costs best practice guide** – We are no longer updating this guide. It is in Section 17 of the *Reference costs guidance for 2012-13*<sup>8</sup> for PLICS users wishing to refer to it.

## Costing principles and standards

4. For this collection, trusts should have due regard to the costing principles and standards set out in *Approved Costing Guidance*. There are also a number of principles specific to reference costs. These are that reference costs:
  - (a) Are calculated on a full absorption basis to identify the full cost of all services listed in subsequent sections of this guidance.

<sup>3</sup> <http://www.hscic.gov.uk/casemix/costing>

<sup>4</sup> <http://www.ic.nhs.uk/casemix>

<sup>5</sup> Following surveys of Grouper documentation which found that, in the main, the NHS were not using the HRG4+ Chapter Listings, the National Casemix Office decided to cease their production from the 2012-13 Reference Costs Grouper onwards. The information held within the Chapter Listings can be found in the Code to Group.

<sup>6</sup> <http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/home>

<sup>7</sup> The NICIP code set is released biannually on 1 April and 1 October each year. Trusts should use the October release that matches the reference costs year, i.e. October 2014 for 2014-15 reference costs.

<sup>8</sup> <https://www.gov.uk/government/publications/reference-costs-guidance-for-2012-13>

- (b) Are retrospective, and the quantum of costs used in their production should be reconciled to the audited accounts. Movements in provisions, e.g. for bad debts, redundancy, or reorganisation, that are reflected in the income and expenditure account should be included in the quantum of costs. The reconciliation statement that forms part of the return is an integral element of the audit trail for this reconciliation.
  - (c) Are average unit costs, irrespective of the underlying data supporting their calculation.
  - (d) Include the costs of drugs or devices against the relevant HRGs, even if the drugs or devices are excluded from the national tariff or separately reported as a memorandum item in the reconciliation statement workbook (paragraph 497). The relevant HRG will be an unbundled high cost drug HRG if the drug has a high cost drug OPCS-4 code, otherwise it will be a core HRG or other unbundled HRG.
  - (e) Emphasise the cost of delivering the service, and not the location of the service or the funding streams that are used to recover these costs. The services covered are those provided to NHS patients regardless of location under a range of contractual arrangements (e.g. with local authorities for public health services, NHS England for prescribed specialised services, or clinical commissioning groups (CCGs) for other services) where the provider incurs a cost.
5. This guidance sets out the requirements for capturing activity to derive unit costs from total costs. As a starting point, we recommend working through the guidance to determine which services the trust provides and how to count activity needed for each service. Include all activity unless we state in [Section 13](#) that it should be excluded.

## Main changes for 2014-15

6. The changes we are making to the reference costs collection in 2014-15 are designed to:
- (a) support the development of price setting, and the development of the scope and design of currencies;
  - (b) ensure high quality and relevant data are collected; and to
  - (c) minimise the administrative burden of national cost collections.
7. The general feedback has been that the guidance for 2013-14 was of a high standard, this was re-enforced by the Capita data assurance programme<sup>9</sup>. With this in mind we have made minimal changes for this year's guidance. A consistent approach to reference costs will help to support PLICS implementation in the future.

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

8. Whilst it will be for Monitor and the NHS England to decide to what extent 2014-15 reference costs are used to set national prices, we are making a number of changes

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[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/319355/PbR\\_DAF\\_costing\\_briefing\\_June\\_2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319355/PbR_DAF_costing_briefing_June_2014.pdf)



to support the development of price setting, and currencies to which prices could be applied in the future.

9. Work is currently ongoing with a small number of providers to test the methodology for reporting reference costs net of education and training. It is expected that we will invite a significantly increased and representative sample of trusts to resubmit their 2014-15 reference costs net of education and training costs in Autumn 2015
10. This exercise will inform the approach to submitting reference costs in 2015-16. We would encourage trusts to get involved in this exercise to help address any potential issues with the proposed methodology and also prepare for any future changes to the collection exercise.
11. Please note this work has no impact on the approach and timescales associated with 2014-15 reference costs
12. The start of the collection window for education and training is once again expected to be aligned with the start of reference costs and close two weeks later. Work is ongoing to reflect feedback from NHS provider organisations around the deadlines for initial submissions and start of the resubmission period, with the potential that resubmissions will be restricted and controlled by the Department.
13. We have made a number of small changes to mental health services ([Section 9](#)). This is following consultation with Monitor, NHS England and following meetings with various mental health providers.
14. The changes to mental health services are primarily the introduction of some new categories:
  - (a) For initial assessment charges – IA98 “patient assessed but not accepted into services” (this is a collection currency only and not a new cluster as part of the MHMDS).
  - (b) Under Specialist mental health services we have reintroduced the category “other specialist mental health services” for inpatient services.
  - (c) We have introduced separate categories under specialist mental health teams for liaison services. Providers will now be required to separate the costs and activity for the different types of Liaison services.
  - (d) We have also included a separate category under specialist mental health teams for “Psycho-sexual services”.
  - (e) Finally, we have also removed the requirement for providers to move the costs of community teams visiting patients who are admitted into the inpatient cost quantum. The costs of these contacts with inpatients will remain in the non-admitted cost quantum for the cluster.
15. Monitor and NHS England are committed to developing currencies and payment systems for community services. The community tariff working group is considering a number of innovative approaches. We have also met with community trusts who identified improvements that could be made to the reference costs guidance and collection around definitions, currencies, and excluded services.
16. Further to this we have recently formed a community reference costs advisory group in an attempt to ascertain the costing issues occurring in community services and

attempt to resolve them by amending the guidance following discussion with that forum.

17. As a result, we have made some changes to [Section 10](#), including the introduction of an extra currency for wheelchair services, and the refinement of other costing categories. These changes are designed to promote costing in community services whilst longer term development work continues. Specifically, we are
  - (a) Adding an extra currency to wheelchair services, in addition to the new set of currencies added last year we have introduced a currency for “specialist modifications without supply of chair”.
  - (b) Introducing a “Special schools” category to nursing services as it has different costs and is separately funded.
  - (c) Aligning the activity measure of a community group session to the mental health services definition. This means that activity is now counted per patient attending a session rather than the number as one group.
  - (d) Re-introducing the community rehabilitation teams for single condition community rehabilitation as removal of this last year left these teams with no obvious method of reporting their costs and activity.

### Collecting high quality and relevant data

18. We are going to re-start the collection of cost and activity sub-contracted by providers to the independent sector (paragraph 32). The contracted out services will be collected at HRG level.

### Minimising the administrative burden of national data collections

19. The Department and its Arms' Length Bodies (ALB's) are signatories to the concordat for reducing the administrative burden arising from national requests for information. The concordat commits signatories to core principles governing the collection of data from NHS bodies, and to a collaborative approach and systematic approach to data collections across the health and social care system.
20. In the 2013-14 reference costs survey trusts reported spending, on average, 93 days collating and submitting the reference costs return. We are conscious of the increasing demands on costing teams as the PLICS collection and the education and training collection develop. We are therefore committed to taking steps to simplify the reference costs collection; we aim to achieve this in 2014-15 by making minimal changes to the previous year.
21. As indicated in paragraph 9, we are also working towards a position where trusts will exclude from reference costs the cost of, rather than the income from, funding streams such as education and training. This will help to remove the requirement for separate collections and instead create an integrated collection exercise.

### Possible changes for 2015-16

22. The PbR data assurance programme found that there were some areas of guidance which could be improved, specifically around chemotherapy and radiotherapy. Capita are going to supply us with the details of the providers who had specific issues and

we will form a working group to try to overcome them.

23. We are aware that as the shift towards treatment in community settings increases we need more robust methods of collecting that data for reference costs. We will, in partnership with the sector, investigate the best way to ensure we capture the full costs of services regardless of where they are carried out.
24. We will continue to develop currencies in community services and mental health services to improve the quality of the data collected. We will examine the inclusion of the collection of the number of patients treated as well as the number of contacts for community teams.
25. We will look into the possibility of a pilot collection in community services using the Community Healthcare Groups (CHG's), which are currently being developed by HSCIC. The CHG's will be based on the Children and Young People's Health Services Data Set (CYPHS), further information can be found here<sup>10</sup>. The potential use of the CHG's for a pilot collection will be discussed at a future community RCAG when we have more information.
26. We will introduce a new collection of cluster costs for IAPT services; this follows a pilot exercise by the NHS England development team and the mandatory clustering of IAPT services from April 2015<sup>11</sup>. We will work closely with NHS England and the pilot group throughout the year to ensure that we have robust guidance and worksheets in place for the collection of this data in 2015-16.
27. We will introduce a new collection of forensic inpatient mental health services on a cluster basis. We will work closely with NHS England and the pilot group throughout the year to ensure that we have robust guidance and worksheets in place for the collection of this data in 2015-16.
28. We are, along with NHS England, investigating the costing treatment of short shelf life drugs. We will be speaking to providers to find out how these drugs are currently treated and will include detailed guidance next year to ensure consistency.

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<sup>10</sup> <http://www.hscic.gov.uk/maternityandchildren/CYPHS>

<sup>11</sup> <http://www.iapt.nhs.uk/pbr/>

## Scope

29. The Review of Central Returns Committee (ROCR)<sup>12</sup> has previously approved this collection under reference number ROCR/OR/2132/FT6/002MAND. A new licence is pending, and it is therefore mandatory for all<sup>13</sup> NHS trusts and NHS foundation trusts in existence between 1 April 2013 and 31 March 2014 to comply with this guidance and its timescales.
30. We based our evidence to ROCR on the administrative burden of collating and submitting reference costs on findings from the 2013 reference costs survey. ROCR are also keen to receive feedback on central data collections from colleagues who submit returns, in particular information about the length of time data collections take to complete and any issues, suggested improvements or duplication. Feedback should be submitted to ROCR using an online form<sup>14</sup>.
31. Trusts should submit unit costs for all services relating to their own provider function, including services delivered under Any Qualified Provider (AQP), but excluding services listed in [Section 13](#). In line with guidance for provider-to-provider agreements (paragraph 485), the receiving trust should include costs and activity for services it sub-contracted to other trusts.
32. NHS providers sub-contract work to the independent sector in a number of circumstances such as when they are unable to meet capacity requirements. NHS providers who sub-contract work outside of the NHS, either to private or charitable sector organisations, are required to include this information in their reference costs return to the same level of detail as for the provision of their own services. This will assist in understanding the cost differentials between the NHS and independent sectors. There is, however, no requirement to separately identify work sub-contracted to other NHS providers.
33. NHS trusts and NHS foundation trusts may therefore need to include two data types in their return, depending on whether they receive health care activity from independent sector providers, covering
  - (a) the costs of their own provider function (data type OWN in the workbook)
  - (b) the costs to them of sub-contracting services to the independent sector (data type OUT in the workbook), with the exception of mental health care clusters (paragraph 300).
34. In line with Treasury's *Financial Reporting Manual*, combining two or more public bodies or transferring functions from one part of the public sector is accounted for using absorption rather than merger accounting. Thus:
  - (a) where trust A is dissolved in-year, e.g. on 30 June 2013, and is acquired in-year by trust B, e.g. on 1 July 2013, it is the responsibility of trust B to ensure a single 2013-14 reference costs return combining the costs and activity of both

<sup>12</sup> <http://www.hscic.gov.uk/baas>

<sup>13</sup> With the exceptions of Calderstones Partnership NHS Foundation Trust and NHS Direct, who are not required to submit reference costs.

<sup>14</sup> <http://www.hscic.gov.uk/3939>

trust A and B is submitted by the mandatory deadline. When completing the reconciliation statement, trust B will need to reconcile to the sum of two sets of accounts: one covering trust A from 1 April 2013 to 30 June 2013, and one covering trust B from 1 April 2013 to 30 June 2013 and trust A and B combined from 1 July 2013 to 31 March 2014

- (b) where trust C is dissolved on 31 March 2014 and is acquired by trust D on 1 April 2014, a separate reference costs return will be required for trust C, which will be completed by trust D in addition to trust D's own return
  - (c) where there is a transfer of function from trust E to trust F and neither trust dissolves, each trust will account for the transferred function for the period they provided the service. Reference costs will follow the financial accounts and no adjustment will be required. A complication with absorption accounting is that any assets transferred between the bodies could result in a gain or loss in the Statement of Comprehensive Income. Any such gain or loss should not be included when calculating reference costs and is not included in the reconciliation statement.
35. It may be necessary to speak to financial accounts colleagues about any such transfers within the organisation.
36. Successful applicants to NHS foundation trust status during the financial year must submit one full year's reference costs for the sum of the NHS trust and the NHS foundation trust.
37. Where a spell begins in the preceding reference costs year and continues into the current reference costs year, all associated finished consultant episodes (FCEs) should be included. Where a spell begins in the current reference costs year and continues into the next reference costs year all associated FCEs should be excluded.

## Timetable

38. Table 2 gives a high level timetable for 2014-15 reference costs.

**Table 2: Reference costs timetable**

Date	Milestone
February 2015	<i>Reference costs guidance for 2014-15</i> published Release of draft REFC and SPELLS workbooks
23 March 2015	Release of HRG4+ 2014-15 Reference Costs Grouper and documentation
April 2015	Release of Unify2 compliant REFC and SPELLS test workbooks
May 2015	Release of Unify2 compliant REFC and SPELLS final workbooks
22 June 2015	Reference costs collection window opens
31 July 2015	Reference costs collection window closes
August – September 2015	Analysis of data
September 2015	Release of draft Reference Cost Index (RCI) on Unify2
October 2015	Publication of national schedules of reference costs, final RCIs and source data

39. Table 3 describes the six week reference costs collection window<sup>15</sup> in more detail.

**Table 3: Collection window**

<sup>15</sup> Separate education and training costs guidance describes the window for that collection in more detail.

Week	Date	Milestone	Notes
1	22 June 2015	Collection window opens	<b>Finance Directors that are ready to sign off REFC (and SPELLS if appropriate) may do so at any time from this date.</b>
5	24 July 2015	Deadline for initial REFC( and SPELLS if appropriate) submissions	Experience from previous years suggests that trusts that wait until the final week of the window before making an initial submission face the biggest challenge in terms of timeliness and accuracy. <b>Trusts must make an initial submission of REFC (and SPELLS if appropriate) by this deadline.</b>
6	27 July 2015	Last possible date for Finance Directors to sign off REFC (and SPELLS if appropriate). Only Finance Directors will have Unify2 accounts with sign off rights. Finance Directors unable to sign off on their designated date should contact us to agree an alternative date within the window, or to agree a named deputy who will be granted a temporary Unify2 account with sign off rights.	London. See Annex B.
6	28 July 2015		South of England. See Annex B.
6	29 July 2105		Midlands and East of England. See Annex B.
6	30 July 2015		North of England. See Annex B.
6	31 July 2015		Collection window closes.

## Resubmissions of data

40. Once the collection has closed, trusts will not be allowed to resubmit data via Unify2.
41. During the analysis of submissions between August 2105 and September 2015, the reference costs team will contact trusts if analysis suggests there may be an error in their data. Trusts will be required to investigate their submission further and report back on any errors found. An impact analysis will be performed by the reference costs team between the original submitted data and the corrected data. Only where a trust has errors in their data that would materially affect national average unit costs will a resubmission via Unify2 be authorised.
42. Trusts with data errors which do not have a material impact on national average unit cost but which impact on their Reference Costs Index (RCI) will have their RCI annotated in the publication, so users of the data are aware, if for example they are making comparisons between trusts.



## NHS Data Model and Dictionary

43. Where possible, we have aligned the requirements of the reference cost collection with the definitions in the NHS Data Model and Dictionary<sup>16</sup> (the Data Dictionary) and included links in this guidance.

### Treatment function codes

44. Admitted patient care, outpatient, and some unbundled services should be reported by treatment function<sup>17</sup>. The Information Standards Board (ISB) issued the latest changes to treatment function codes (TFCs) in Amd 17/2012<sup>18</sup> in November 2012. These changes have been incorporated into the list of TFCs<sup>19</sup> in the Data Dictionary, but are only available to flow in the latest version of the commissioning data sets (CDS 6.2)<sup>20</sup>. All these TFCs will be available in the reference costs workbook, except those listed in Table 4.

**Table 4: TFCs excluded from the reference costs workbook**

TFC	Description	Rationale	Para
264	Paediatric cystic fibrosis	Costs and activity should be reported against cystic fibrosis year of care currencies	427
343	Adult cystic fibrosis service	Costs and activity should be reported against cystic fibrosis year of care currencies	427
424	Well babies	Costs should be reported under obstetrics (501) or midwife episodes (560), and activity excluded	91
700	Learning disability	Learning disability services are excluded from reference costs	453

### Healthcare resource groups

45. HRGs underpin the national tariff from costing through to payment. They are refined every year in line with changing clinical practice and policy requirements. Reference costs for admitted patient care, outpatients, emergency medicine and unbundled services are collected using the latest version, HRG4+.
46. Trusts must use outputs from the HRG4+ 2014-15 Reference Costs Grouper (the Grouper), and the suite of supporting documentation, when compiling their reference costs.
47. The Grouper will be supported by the underlying primary classification systems and requires inputs from the CDS covering admitted patient care, critical care, outpatients and emergency medicine. The renal dialysis core HRGs for chronic kidney disease are generated by use of fields from the National Renal Dataset rather than from a CDS (paragraph 242).

<sup>16</sup> <http://www.datadictionary.nhs.uk/>

<sup>17</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/classes/t/treatment\\_function\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/classes/t/treatment_function_de.asp?shownav=1)

<sup>18</sup> [http://www.isb.nhs.uk/documents/isb-0028/amd-17-2012/index\\_html](http://www.isb.nhs.uk/documents/isb-0028/amd-17-2012/index_html)

<sup>19</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/t/tran/treatment\\_function\\_code\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/t/tran/treatment_function_code_de.asp?shownav=1)

<sup>20</sup> [http://www.datadictionary.nhs.uk/web\\_site\\_content/cds\\_supporting\\_information/commissioning\\_data\\_set\\_version\\_6-2\\_type\\_list.asp?shownav=1](http://www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/commissioning_data_set_version_6-2_type_list.asp?shownav=1)

48. Unbundled HRGs ([Section 6](#)) are a key design feature in HRG4+. This guidance explains where costs and activity should be reported against unbundled HRGs, and where they should be reported against core HRGs.
49. Table 5 lists HRGs where zero costs should be allocated. We will exclude these HRGs from the workbooks.

**Table 5: Zero cost HRGs**

HRG	Description	Rationale
DZ13A	Cystic Fibrosis with CC Score 1+	Costs should be reported against cystic fibrosis year of care currencies
DZ13B	Cystic Fibrosis with CC Score 0	
PD13A	Paediatric Cystic Fibrosis with CC Score 5+	
PD13B	Paediatric Cystic Fibrosis with CC Score 2-4	
PD13C	Paediatric Cystic Fibrosis with CC Score 1	
PD13D	Paediatric Cystic Fibrosis with CC Score 0	
LA97A	Same Day Dialysis Admission or Attendance, 19 years and over	Costs should be reported against the LD HRGs
LA97B	Same Day Dialysis Admission or Attendance, 18 years and under	
PB03Z	Healthy Baby	Costs should be reported as part of the maternity delivery episode

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

## Primary classifications

51. HRG4+ relies on two underlying primary classification systems:
- the International Statistical Classification of Diseases and Related Health Problems Tenth Revision (ICD-10)
  - the OPCS Classification of Interventions and Procedures (OPCS-4).
52. The NHS should have implemented:
- ICD-10 4th Edition on 1 April 2012, as notified in ISB 0021<sup>21</sup>. The NHS Classifications Service have provided updated data files and training materials<sup>22</sup> for the NHS and system suppliers
  - OPCS-4.7, released to the service in April 2014<sup>23</sup>
53. These revisions underpin HRGs in the HRG4+ 2014-15 Reference Costs Grouper.

## Queries

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

<sup>21</sup> <http://www.isb.nhs.uk/library/standard/119>

<sup>22</sup> <http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/icd10/icd10updates/index.html>

<sup>23</sup> <http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4>



55. The Unify2 forum is an informal forum for NHS costing colleagues. We also use it to post other relevant materials in the lead up to the collection window.
56. Queries about HRGs and the HRG4+ 2014-15 Reference Costs Grouper should be directed to [enquiries@ic.nhs.uk](mailto:enquiries@ic.nhs.uk), and queries about clinical coding and the Data Dictionary to [datastandards@nhs.net](mailto:datastandards@nhs.net).
57. For queries requiring an official response:
  - (a) NHS trusts with queries that cannot be resolved using these resources should contact the NHS Trust Development Authority (NHS TDA) at [tda.finplan@nhs.net](mailto:tda.finplan@nhs.net) in the first instance
  - (b) NHS foundation trusts should contact us directly at [ReferenceCosts@dh.gsi.gov.uk](mailto:ReferenceCosts@dh.gsi.gov.uk).

## Section 2: Data quality, validation and assurance

### Introduction

58. This section describes:
- the validations that will be performed on the cost data during the collection window to help improve quality;
  - the self-assessment quality checklist that must be completed alongside reference cost returns; and
  - the requirement for Boards to approve the costing process and Finance Directors to sign off the cost data.
59. Accurate cost data is fundamentally important to support the joint responsibility of Monitor and NHS England for pricing NHS services in England.
60. It is also important to note that the accuracy is important for NHS providers and commissioners as they use the data for reporting to executive teams, benchmarking, contract negotiations and local pricing of non-tariff areas.
61. Reference costs also support the Department's commitment to improving data transparency and making information available to the public as set out in its business plan for 2013 to 2015<sup>24</sup>

### Mandatory validations

62. Our mandatory validations are designed to assure the basic integrity of the data submitted. All validations are embedded within the relevant workbooks. Trusts will not be able to sign off their returns until their data passes each of the validations found in Table 6.

**Table 6: Mandatory validations**

No.	Validation	Description	Workbook	Worksheet
1	Activity = integer	Activity must be an integer	Both	All
2	Activity > 0	Activity must be positive	Both	All
3	Activity and unit cost	If activity is reported, then a unit cost must be reported, and vice versa	Both	All
4	Bed days > = FCEs	Number of inlier bed days must be greater than or equal to FCEs	Both	IP
5	Duplicate entry	Each combination of department code, service code and currency code must be unique	REFC	All
6	Excess bed day costs without excess bed day activity	If excess bed day costs are reported, then excess bed day activity must be reported, or vice versa	REFC	IP
7	Excess bed days without inlier activity	If excess bed day costs are reported, inlier activity must be reported	Both	IP

<sup>24</sup> <https://www.gov.uk/government/publications/department-of-health-business-plan-2013-to-2015>

No.	Validation	Description	Workbook	Worksheet
8	Inlier bed days <= HRG trim point * no. of FCEs	Inlier bed days must be less than or equal to the HRG trim point multiplied by number of FCEs	Both	IP
9	Invalid code	Department code (e.g. DC), service code (e.g. 100) or HRG code (e.g. AA02C) is invalid	REFC	Flexible <sup>25</sup>
10	Memorandum information	The following memorandum information must be supplied in addition to unit cost and activity: <ul style="list-style-type: none"> <li>- number of adult critical care periods</li> <li>- average number of home haemodialysis sessions per week</li> <li>- number of direct access pathology tests</li> <li>- average cluster review period and number of completed cluster review periods</li> </ul>	REFC	CC, RENAL, DAP, MHCC
11	Missing code	Missing department, service or currency code within a row of data	REFC	Flexible
12	Missing costs and activity	Codes have been supplied, but no unit costs or activity	REFC	Flexible
13	NEL LoS >= 2	Average length of stay, ((number of inlier bed days + excess bed days) / number of FCEs), must be greater than or equal to 2 for non-elective long stays	REFC	IP
14	Quantum	The sum of unit costs multiplied by activity must be within +/- 1% of the reconciliation statement	REFC	N/A
15	SPELLS vs REFC	Total spell costs must reconcile to within +/- 0.1% of total FCE inlier and excess bed day costs by each admission type (day case, ordinary elective, and ordinary non-elective)	Both	N/A
16	Unit cost = #.##	Unit cost must be to two decimal places	REFC	All
17	Unit cost >= 0.01	Unit cost must be positive and greater than or equal to £0.01	REFC	All worksheets except those listed in 16 and 17
18	Unit cost >= 05	Unit cost must be positive and greater than or equal to £5.00	REFC	OPATT, OPPROC, CR, IMAG, HCD, REHAB, SPC
19	Unit cost >= 20	Unit cost must be positive and greater than or equal to £20.00	Both	DC, IP, CMDT

## Non-mandatory validations

63. Our non-mandatory validations are designed to improve the quality and accuracy of the data. In addition to building these into the workbooks, we will post regular feedback, in the form of an MS Excel spreadsheet showing the number of outstanding non-mandatory validations by provider, on the Unify2 forum during the collection window.

<sup>25</sup> Flexible worksheets have not been pre-populated with data. Flexible worksheets have been pre-populated with applicable department, service and currency code combinations.

64. A non-mandatory validation is not in itself an indication that the data are incorrect, and there are many valid reasons why data may not pass a non-mandatory validation, for example a small number of high cost episodes may result in an average unit cost greater than £50,000. Nevertheless, it is a requirement for trusts to consider these validations and make any necessary revisions, confirming the extent to which they have done so on the self-assessment quality checklist.
65. The feedback we have received has been that the non-mandatory validations in 2013-14 were a great improvement on previous years. With that in mind we have kept the same validations for 2014-15. Table 7 gives full details.

**Table 7: Non-mandatory validations that require investigation**

No.	Validation	Work book	Work sheets	Materiality threshold	Exceptions
1	Cost is less than an expected minimum cost for a high cost device that is always a component of an HRG's costs	Both	DC, IP, OPPRO C	None	None
2	Day case unit cost is more than double the ordinary elective unit cost for the same HRG and the same TFC	Both	DC, IP	More than 10 day case FCEs and more than 10 ordinary elective FCEs	None
3	FCE to spell ratio by HRG is less than 1.00 or greater than 1.80	SPELLS	DC, IP	More than 10 FCEs and more than 10 spells	None
4	Follow up unit cost is more than double the first unit cost for the same outpatient attendance in the same TFC	REFC	OPATT	More than 10 follow ups and more than 10 firsts	None
5	Non consultant led unit cost is more than double the consultant led unit costs for the same outpatient attendance in the same TFC	REFC	OPATT	More than 10 non consultant led and more than 10 consultant led	None
6	Outliers: unit cost is less than one-tenth or more than 10 times the national mean unit cost. The workbooks will use 2013-14 means. During the collection window, we recommend that trusts refer to the verification report in Unify2, which is updated overnight and shows real time means.	Both	All	More than 10 activities	None
7	Paediatric critical care HRGs are being reported by the expected organisations in Table 12: Providers of ECMO, ECLS or aortic balloon pump and Table 13: Providers with paediatric intensive care units only	REFC	CC	N/A	None
8	Single professional unit cost is more than double the multi professional unit cost for the same outpatient attendance in the same TFC.	REFC	OPATT	More than 10 single and more than 10 multi	None
9	Unit cost over £50,000	Both	All	None	HRGs which have a 2014-15 national average mean unit cost greater than £50,000 are excluded

No.	Validation	Work book	Work sheets	Materiality threshold	Exceptions
10	Unit cost under £5	REFC	All	None	The following services are excluded: <ul style="list-style-type: none"> <li>• Ambulance service calls</li> <li>• Direct access pathology</li> <li>• Mental health care clusters</li> </ul>
11	Variance between 2013-14 and 2014-15 total costs or total activity is greater than 25%. The workbook analysis will be at worksheet level. The Unify2 forum feedback will be by department and HRG sub-chapter for acute services, and department, service and currency for non-acute services	REFC	All	None	None

66. The workbooks will include more detail about how these validations should be used.

## Self-assessment quality checklist

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

68. The self-assessment quality checklist in Table 8 must be completed by all trusts.

**Table 8: Self-assessment quality checklist**

Check	Response
<b>Total costs:</b> The reference costs quantum has been fully reconciled to the signed annual accounts through completion of the reconciliation statement workbook in line with guidance	<ul style="list-style-type: none"> <li>○ Fully reconciled to within +/- 1% of the signed annual accounts</li> <li>○ Fully reconciled to within +/- 1% of the draft annual accounts [state reason]</li> </ul>
<b>Total activity:</b> The activity information used in the reference costs submission to report admitted patient care, outpatient attendances and A&E attendances has been fully reconciled to provisional Hospital Episode Statistics and documented	<ul style="list-style-type: none"> <li>○ Fully reconciled and documented</li> <li>○ Partly reconciled</li> <li>○ n/a – reconciliation completed but to another source [state reason]</li> <li>○ Not reconciled</li> </ul>
<b>Sense check:</b> All relevant unit costs <sup>26</sup> under £5 have been reviewed and are justifiable	<ul style="list-style-type: none"> <li>○ All relevant unit costs under £5 reviewed and justified [state reason]</li> <li>○ n/a – no relevant unit costs under £5 within the submission</li> </ul>
<b>Sense check:</b> All relevant unit costs <sup>27</sup> over £50,000 have been reviewed and are justified	<ul style="list-style-type: none"> <li>○ All relevant unit costs over £50,000 reviewed and justified [state reason]</li> <li>○ n/a – no relevant unit costs over £50,000 within the submission</li> </ul>
<b>Sense check:</b> All unit cost outliers (defined as unit costs less than one-tenth or more than ten times the previous year's national mean average unit cost) have been reviewed and are justifiable	<ul style="list-style-type: none"> <li>○ All unit cost outliers reviewed and justified [state reason]</li> <li>○ n/a – no unit cost outliers within the submission</li> </ul>

<sup>26</sup> Exceptions are listed in Table 7.

<sup>27</sup> Exceptions are listed in Table 7.

Check	Response
<p><b>Benchmarking:</b> Data has been benchmarked where possible against national data for individual unit costs and for activity volumes (the previous year's information is available in the National Benchmarker<sup>28</sup>)</p>	<ul style="list-style-type: none"> <li>○ All cost and activity data within the submission has been benchmarked using the National Benchmarker prior to submission</li> <li>○ All cost and activity data within the submission has been benchmarked using another benchmarking process [state]</li> <li>○ Some but not all cost and activity data within the submission has been benchmarked using the National Benchmarker prior to submission</li> <li>○ Some but not all cost an activity data within the submission has been benchmarked using another benchmarking process [state]</li> <li>○ No benchmarking performed on the cost data prior to submission</li> </ul>
<p><b>Data quality:</b> Assurance is obtained over the quality of data for 2014-15</p>	<ul style="list-style-type: none"> <li>○ An external audit has been performed on data quality</li> <li>○ An internal audit has been performed on data quality</li> <li>○ Internal management checks have provided assurance over data quality</li> <li>○ Assurance has been obtained over data quality but not for 2014-15</li> <li>○ No assurance has been obtained over data quality</li> </ul>
<p><b>Data quality:</b> Assurance is obtained over the reliability of costing and information systems for 2014-15</p>	<ul style="list-style-type: none"> <li>○ An external audit has been performed on costing and information system reliability</li> <li>○ An internal audit has been performed on costing and information system reliability</li> <li>○ Internal management checks have provided assurance over costing and information system reliability</li> <li>○ Assurance has been obtained over costing and information system reliability but not for 2014-15</li> <li>○ No assurance has been obtained over costing and information system reliability</li> </ul>
<p><b>Data quality:</b> Where issues have been identified in the work performed on the 2014-15 data and systems, these issues have been resolved to mitigate the risk of inaccuracy in the 2014-15 reference costs submission</p>	<ul style="list-style-type: none"> <li>○ All exceptions have been resolved and the risk of inaccuracy in the 2014-15 reference costs submission fully mitigated</li> <li>○ Some exceptions have been resolved but not all</li> <li>○ Exceptions have yet to be resolved</li> <li>○ n/a – no exceptions noted</li> </ul>
<p><b>Data quality:</b> All other non-mandatory validations as specified in the guidance and workbooks have been considered and any necessary revisions made</p>	<ul style="list-style-type: none"> <li>○ All non-mandatory validations have been considered and necessary revisions made</li> <li>○ All non-mandatory validations have been considered and some but not all necessary revisions have been made [specify and state reason]</li> <li>○ Some non-mandatory validations have been considered and necessary revisions made [specify and state reason]</li> <li>○ No non-mandatory validations have been investigated [state reason]</li> <li>○ n/a – no non-mandatory validations have occurred</li> </ul>

<sup>28</sup> <http://www.chks.co.uk/national-benchmarker>

## Board approval and Finance Director sign off

69. The Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee, is required to confirm in advance of the reference costs submission (for example at the April 2015 or May 2015 Board meeting) that it is satisfied with the trust's costing processes and systems, and that the trust will submit its reference cost return in accordance with this guidance. In providing this confirmation, Boards or their appropriate sub-committees may wish to satisfy themselves that procedures are in place to ensure that the self-assessment quality checklist can be completed at the time of the reference cost submission.
70. Trusts that are unable to provide this confirmation should provide details of non-compliance. Specifically, Boards or their appropriate sub-committees are required to confirm that:
- (a) costs will be prepared with due regard to the principles and standards set out in Monitor's *Approved Costing Guidance*;
  - (b) appropriate costing and information capture systems are in operation;
  - (c) costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance; and
  - (d) procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return.
71. The Finance Director is required to sign off the reference costs return in Unify2, confirming that:
- (a) the Board or its appropriate sub-committee has approved the costing process ahead of the collection;
  - (b) the self-assessment quality checklist has been completed and used to improve quality and to provide assurance to the Department about the accuracy of the return; and
  - (c) finance teams have actively engaged clinicians and other relevant non-finance stakeholders in the costing process.
72. A Trust's reference costs submission should be subjected to the same scrutiny and diligence as any other financial returns submitted by the Trust. As the designated lead nominated to submit the reference costs submission, the Director of Finance is the senior professional responsible for the data used to inform tariff, and as a result ensuring that the National Tariff functions in a manner that benefits the service overall. Material errors in reference costs submissions will not only impact on the accuracy of any resultant tariff, but may also have an impact on the provider licence for foundation trusts, and applications for FT-status at aspiring trusts.
73. In submitting a Trust's reference costs return, the Director of Finance is stating that they have discharged their responsibility to scrutinise and challenge the organisations costing information, and has satisfied themselves that the submission is correct.

74. Evidence from the PbR Data Assurance Framework Review of 2014<sup>29</sup> reference costs submissions has shown that organisations with good costing are usually found to have the following characteristics:
- (a) The production of reference costs at a Trust was treated as an ongoing process with accuracy checkpoints throughout the year.
  - (b) The Trust had a high level of clinical engagement. Where clinicians feel engaged with the costing process they are more likely to scrutinise their own cost information and may be encouraged to review their own behaviour leading to an improved experience for the patient.
  - (c) That an engaged and informed board always resulted in more accurate costing at an organisation.
75. As with the 2013-14 reference costs submission we require sign off from the director of finance or an appointed deputy, the data assurance framework re-emphasised that the reference costs submission should be subjected to the same scrutiny as any other financial returns submitted by the organisation.

## External assurance

76. Some trusts will be subject to external review as part of a wider external assurance programme.
77. Under the Health and Social Care Act 2012, Monitor took over the responsibility for the Payment and Tariff Assurance Framework (previously the PbR Data Assurance Framework on 1 April 2014). On Monitor's behalf Capita are auditing the arrangements for submission of reference cost returns, and the quality and accuracy of data. In 2014/15, unlike in previous years, all trusts selected will be subject to a combined costing audit (analysing reference costs) and a coding audit. Monitor will meet with the Chief Executive, Audit Chair and Finance Director at the start of an audit to explain its scope, and Monitor's responsibilities in relation to this.

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<sup>29</sup> <https://www.gov.uk/government/publications/payment-by-results-costing-in-the-nhs>



## Section 3: Admitted patient care

### Introduction

78. This section covers the following types of admitted patient care:
- (a) day case electives<sup>30</sup>,
  - (b) ordinary electives<sup>31 32</sup>,
  - (c) ordinary non-electives<sup>33</sup>, and
  - (d) regular day or night admissions<sup>34</sup>.
79. Trusts must submit their admitted patient care costs by Finished Consultant Episode (FCE), Treatment Function Code (TFC) and Healthcare Resource Group (HRG).
80. Trusts must also submit, in a separate spells workbook, their admitted patient care costs (excluding regular day or night admissions) by spell and HRG.
81. The HRG4+ 2014-15 Reference Costs Grouper will attach a core HRG to every FCE or spell. Trusts will only report core HRGs here. Trusts will report the costs of unbundled HRGs separately as described in [Section 6](#), with the exception of unbundled diagnostic imaging HRGs, the costs of which will be included with the core HRGs reported here.

### FCE costs

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

#### Ordinary non-elective short stays and long stays

83. National prices for non-electives include short stay emergency adjustments to ensure that emergency stays of less than two days, where the average length of stay of the HRG is longer, are appropriately reimbursed.
84. All ordinary non-elective activity in both the FCE and spell collections must therefore be separately identified as long or short stay by:
- (a) completing the input fields required by the Grouper for critical care, rehabilitation and specialist palliative care length of stays;

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<sup>30</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/p/pati/patient\\_classification\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1)

<sup>31</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/p/pati/patient\\_classification\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1)

<sup>32</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/e/elective\\_admission\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/e/elective_admission_de.asp?shownav=1)

<sup>33</sup> All national codes excluding 11, 12 and 13 at

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/a/add/admission\\_method\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1)

<sup>34</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/p/pati/patient\\_classification\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1)

- (b) processing the data through the Grouper, which deducts these stays from the core stays; and
- (c) classifying the data, after these length of stay adjustments, as follows,
  - (i) long stay – length of stay (number of inlier plus excess bed days divided by number of FCEs) equal to two or more days; or
  - (ii) short stay – length of stay equal to one day. The Grouper automatically adds one day to admissions with a zero length of stay (where the patient has been allowed home on the same day as the admission), so short stays should always have a length of stay of one.

### Excess bed days and trim points

- 85. Excess bed day costs must be reported separately for ordinary elective and ordinary non-elective FCEs but not for spells. Spell unit costs should be untrimmed.
- 86. The cost per day for excess bed days should generally include only the costs associated with the ward cost pool group, and any other relevant costs such as blood tests, drugs, dressings, or therapies. We would expect that care of patients is less intensive than at the beginning of the FCE and that costs would be less per day than for the truncated HRG, although we recognise that active treatment does sometimes continue beyond the trim point especially for specialised services.
- 87. Trusts should use the trim points included in the HRG4+ 2014-15 Reference Costs Grouper and supporting documentation to calculate HRG length of stay and associated excess bed days.
- 88. Some HRGs have a trim point of 32,000 days. This is due to insufficient data available to calculate valid trim points or where maximum length of stay logic is included in the HRG4+ design.

### Regular day or night admissions

- 89. Regular day or night admissions<sup>35</sup> are reported in the FCE collection but not the spells collection. Admissions for specialist care such as cystic fibrosis, radiotherapy, or renal dialysis should be reported against the relevant sections of the collection, and not here.

### Obstetrics and maternity admitted patient episodes

- 90. Pathway costs for maternity are not being collected for 2014-15.
- 91. All obstetrics and maternity admitted patient episodes should be reported under obstetrics (TFC 501) or midwife episodes (TFC 560) and, in line with Data Dictionary guidance on admission method<sup>36</sup>, as non-elective.
- 92. All activity relating to HRG PB03Z (healthy baby) or TFC 424 (well babies) should be excluded. Associated costs should be reported as part of the total costs of the maternity delivery episode against the relevant HRG. Note that the Data Dictionary defines TFC 424 as “care given by the mother or substitute with medical and

<sup>35</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/p/pati/patient\\_classification\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1)

<sup>36</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/a/add/admission\\_method\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1)

neonatal nursing advice if needed". TFCs describe the carer, in this case the mother or substitute. We would expect trusts to use the TFC of the appropriate care professional (obstetrician, paediatrician or consultant midwife) rather than TFC 424 for babies with a minor or major diagnosis (HRGs PB01Z or PB02Z) or receiving a procedure driven HRG. We are aware that some providers will have very small levels of activity coded to HRG PB03Z (healthy baby) or TFC 424 (well babies) with no maternity episode – In these cases the activity should be excluded and the costs treated as an overhead to the relevant service.

93. Babies who are unwell (i.e. any babies that are not defined as well babies, e.g. neonatal level of care 1, 2 or 3) will generate their own admission record. Costs should be reported against the relevant HRG and, where applicable, the unbundled neonatal critical care HRGs.
94. The Grouper includes HRGs that cover ante-natal and post-natal care, scans and other procedures that occur outside the delivery episode. Providers should take care to differentiate accurately and consistently between the costs of this activity.
95. HRGs NZ30\* to NZ51\* cover delivery episodes, and are designed to reflect the costs associated with different types of delivery. When allocating Clinical Negligence Scheme for Trusts (CNST) costs, it should be noted that maternity services often incur a much higher payment than other services, to reflect the sizable claims that arise from complex delivery episodes.
96. Maternity outpatients, scans, screens and tests are covered in paragraph 130. Community midwifery is covered in paragraph 368.

## Renal transplantation

97. Guidance on submitting costs against the adult renal transplantation HRG currencies is in [Annex C](#).

## Spell costs

98. A hospital provider spell<sup>37</sup> is defined as the period of admission to discharge or death for the same patient at the same provider. Where a patient has multiple distinct admissions on the same day (e.g. a planned day case in the morning, discharged, re-admitted in the afternoon for a second day case and then discharged) then each of these admissions should be counted separately. To be consistent with the FCE collection, only spells ending in 2014-15 should be included (paragraph 37).
99. Spells data will be submitted in a separate workbook by all trusts that submit equivalent FCE costs as follows:
  - (a) by admission method (day case, ordinary elective, ordinary non-elective). Unlike FCEs, there is no distinction between non-elective short and long stays;
  - (b) number of spells by HRG. Spells should be assigned based on the SpellReportFlag field in the Grouper. Unlike FCEs, there is no requirement to

<sup>37</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/h/hospital\\_provider\\_spell\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/h/hospital_provider_spell_de.asp?shownav=1)

- differentiate spells by TFC;
- (c) average unit cost per spell by HRG, untrimmed for any excess bed days;
- (d) number of spell inlier bed days by HRG; and
- (e) number of spell excess bed days by HRG (using the trim points differentiated by admission method referred to in paragraph 87).

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

## Section 4: Outpatient services

### Introduction

101. This section covers:

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

102. Outpatient attendances and procedures in outpatients should be reported by HRG and TFC currencies. The Grouper may attach one or more unbundled HRGs to the core HRG produced. Only core HRGs should be reported within this section. Unbundled HRGs should be reported separately ([Section 6](#)).

### Outpatient attendances

103. Outpatient attendances<sup>38</sup> in HRG4+ (WF01\* and WF02\*), generated from a number of mandated fields in the outpatient CDS, are organised by

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

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

105. Outpatient clinics held by a clinician or nurse whilst acting in a private capacity, and which are not part of the trust's income stream, are excluded from reference costs. The same rules apply to outpatient clinics held by a clinician or other primary care practitioner as part of any primary medical services contract.

106. Reference costs do not distinguish between attendances that are pre-booked or not. A different consultant other than the one a patient was admitted under seeing that patient (e.g. for psychiatric assessment of a medical patient), should be reported here as a consultant led outpatient attendance. A patient attending a ward for examination or care will be counted as an outpatient attendance if seen by a doctor. If seen by a nurse, they are a ward attendance<sup>39</sup>. No designated worksheet exists for ward attendances, costs and activity for which should be reported here as non-consultant led outpatient attendances under the appropriate TFC.

#### First and follow up

<sup>38</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/o/out-patient\\_attendance\\_consultant\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/o/out-patient_attendance_consultant_de.asp?shownav=1)

<sup>39</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/w/ward\\_attendance\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/w/ward_attendance_de.asp?shownav=1)

107. First attendances<sup>40</sup> are defined in the Data Dictionary. Follow up attendances are those that follow the first attendance irrespective of whether it happened in a previous financial year. Single professionals seeing a patient sequentially as part of the same clinic should be reported as two separate attendances (a first and a follow-up if professionals are in the same team, or two firsts if they are in a different team).

### Face to face and non-face to face

108. Only non-face to face contacts<sup>41</sup> that directly support diagnosis and care planning and replace a face to face contact should be included in the collection. Telephone contacts solely for informing patient of results are excluded.

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

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

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

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

### Single and multi-professional

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

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

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<sup>40</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/data\\_field\\_notes/f/first\\_attendance\\_de.asp?query=First%20Attendance&rank=100&shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/f/first_attendance_de.asp?query=First%20Attendance&rank=100&shownav=1)

<sup>41</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/c/cons/consultation\\_medium\\_used\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1)

115. These definitions apply when a patient benefits in terms of care and convenience from accessing the expertise of two or more healthcare professionals at the same time. The clinical input of multi-professional or multi-disciplinary attendances must be evidenced in the relevant clinical notes or other relevant documentation.
116. They do not apply if one professional is simply supporting another, clinically or otherwise, e.g. in the taking of notes, acting as a chaperone, training, professional update purposes, operating equipment and passing instruments. They also do not apply where a patient sees single professionals sequentially as part of the same clinic. Such sequential appointments count as two separate attendances, and should be reported in line with existing Data Dictionary guidance on joint consultant clinics<sup>42</sup>.
117. The multi-disciplinary attendance definition does not apply to multi-disciplinary meetings, where care professionals meet in the absence of the patient. Multi-disciplinary meetings should not be recorded as multi-disciplinary attendances.

### Consultant led and non-consultant led

118. The collection requires consultant led and non-consultant led outpatient attendances to be reported separately.
119. Consultant led<sup>43</sup> activity occurs when a consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but takes overall clinical responsibility for patient care. The activity will take place in a consultant clinic, defined as per the mandatory outpatient attendance CDS type 020<sup>44</sup>, using the consultant code field<sup>45</sup>, main specialty code and TFC.
120. Clinics run by general practitioners with a special interest, or specialist therapists, are normally taking patients from what would have been a consultant list, and are classed as consultant led activity.
121. Non-consultant led activity takes place in a clinic where the consultant is not in overall charge (i.e. any activity not covered in paragraph 119). Again, these clinics are identified in the CDS by default codes for non-consultants in the consultant code field, together with the main specialty code and TFC.

### Audiology

122. Audiology assessments should be recorded as procedures in outpatients, using the HRG currencies described in paragraph 342.

### HIV and AIDS

123. Nationally specified currencies HIV adult outpatient services were introduced for

<sup>42</sup> <http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs/cds/outpatact/sharedcare>

<sup>43</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/c/consultant\\_led\\_activity\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_led_activity_de.asp?shownav=1)

<sup>44</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/messages/cds\\_v6-2/data\\_sets/cds\\_v6-2\\_type\\_020\\_-\\_outpatient\\_cds\\_fr.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6-2/data_sets/cds_v6-2_type_020_-_outpatient_cds_fr.asp?shownav=1)

<sup>45</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/c/cons/consultant\\_code\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultant_code_de.asp?shownav=1)



contracting in 2013-14, the full mandated guidance for treatment of these currencies can be found here<sup>46</sup>. The currencies are a clinically designed year of care pathway for three groupings of HIV adult patients (19 years and over). To support the currencies, the HIV and AIDS reporting system (HARS)<sup>47</sup> has been introduced by Public Health England. All trusts providing the HIV outpatient pathways must submit data to HARS. The dataset will support commissioning and epidemiology of HIV adult outpatient activity.

124. We are not collecting pathway costs for the HIV adult outpatient services in 2014-15. However, we are collecting the unit cost of attendances for patients with HIV or AIDS against the three categories.
125. **Category 1 (new patients)** are newly diagnosed or have newly started on antiretroviral therapy (ARV drugs). These patients require more intensive clinical input than stable patients in the first year of diagnosis. This includes a greater number of more complex diagnostic tests and more frequent clinic visits with a greater input from multi-disciplinary teams.
126. **Category 2 (stable patients)** covers patients that do not have one of the listed category 3 complexities and are either not on ARV drugs or started ARV drugs more than one year ago. This category covers the majority of patients and therefore should be used as the default category unless category 1 or 3 criteria can be demonstrated and validated.
127. **Category 3 (complex patients)** covers patients who have a complexity needing high levels of maintenance. Complexities are:
- (a) current TB co-infection on anti-tuberculosis treatment
  - (b) on treatment for chronic viral liver disease
  - (c) receiving oncological treatment
  - (d) active AIDS diagnosis requiring active management in addition to ARV drugs (not inpatient care)
  - (e) HIV-related advanced end-organ disease
  - (f) persistent viraemia on treatment (more than six months on ARV drugs)
  - (g) mental illness under active consultant psychiatric care, and
  - (h) HIV during current pregnancy.
128. The currencies do not include the provision of any ARV drugs. The drugs costs should be included in the unbundled high cost drug HRGs (paragraph 211), and only the associated costs should be included here.
129. The costs of HIV testing and partner notification are part of sexual health and should be reported under sexual health services (paragraph 136).

<sup>46</sup> <https://www.gov.uk/government/publications/hiv-outpatient-pathway-updated-guidance-available>

<sup>47</sup> <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVAndAIDSReportingSystem/>



## Maternity outpatients and scans, screens and tests

130. Maternity outpatients include midwifery antenatal care undertaken by the NHS provider in GP and community based surgeries, which should be included as part of antenatal outpatients where the provider is able to code and electronically flow data. The setting of the outpatient clinic is irrelevant, as long as it fits with Data Dictionary definitions.
131. A number of routine scans, screens and tests are offered to mothers as an integral part of the maternity pathway. Such tests (sexual health, glucose tolerance, ultrasound etc.) are often carried out in obstetrics outpatients or antenatal clinics, but also in admitted patient episodes (particularly amniocentesis, chorionic villus sampling etc.).
132. Where a woman attends the hospital for an ultrasound, scan or screen as part of a non-admitted attendance, this activity should be reported as an outpatient attendance with the appropriate OPCS-4 code for any procedures or interventions carried out, which may result in a procedure driven HRG.
133. Where a woman is admitted to hospital and part of her care includes an ultrasound, scan or screen, this activity should be recorded as part of that admitted patient episode.
134. The costs of carrying out the tests should be treated as an indirect cost to the relevant maternity HRG or attendance. Pathology costs from analysing routine tests should also be treated as an indirect cost to the relevant maternity HRG or attendance. The costs of analysing samples that are undertaken under a separate commissioner contract (such as genetics, DNA, RNA, biochemistry analysis for downs syndrome, specialist diagnostic laboratories etc.) should not be included in the obstetrics or maternity reference costs.

## Paediatric treatment function codes

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

## Sexual and reproductive health services

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

## Therapy services

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[http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/s/sexual\\_and\\_reproductive\\_health\\_clinic\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/s/sexual_and_reproductive_health_clinic_de.asp?shownav=1)

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

## Procedures in outpatients

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

## Cancer multi-disciplinary teams

139. There is only one exception to the non-face to face rule in paragraph 108 and this is for specific cancer multi-disciplinary team (MDT) meetings to discuss a patient. Cancer MDTs have been defined by the National Institute for Health and Clinical Excellence (NICE) as essential to the delivery of high quality cancer care.

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

- (a) breast
- (b) colorectal
- (c) local gynaecological - local teams diagnose most cancers, provide treatment for some types of cancer, and refer people on to the specialist teams if necessary.
- (d) specialist gynaecological - specialist teams provide specialist care and treatment for people whose cancer is less common or who require specialist treatment for other reasons
- (e) specialist upper gastrointestinal
- (f) other.

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

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

143. The unit cost is per individual patient treatment plan discussed. MDTs will always have a defined consultant lead, who is responsible for chairing the meeting and ensuring treatment decisions are recorded. Therefore, MDT costs should be reported as consultant led, multi-professional, non-face to face, first attendances (HRG WF02D) by MDT type.

144. Include consultant costs based on job plans, preparation for peer review, support staff costs, and administration costs such as arranging MDT initiated investigations and follow-up clinics. Exclude costs such as communicating the MDT outcome by phone to the patient.
145. Although an MDT may draw on membership from several NHS providers, only the host organisation responsible for its running must report the costs, including the costs of its own team and overhead costs arising from the caseloads of other organisations.

## Section 5: Emergency medicine

146. This section covers all emergency medicine attendances at each of four A&E department types, defined by the sub-chapter VB HRGs, supported by the A&E minimum dataset<sup>49</sup>, and split between
- (a) patients who are admitted for further investigation or treatment rather than discharged from A&E; and
  - (b) patients who are not admitted but are discharged or die whilst in A&E.
147. Emergency departments (national code 01) and consultant led mono-specialty accident and emergency services (national code 02) may be 24 hour or non-24 hour.
148. Other types of A&E or minor injury (national code 03) include minor injury units and urgent care centres.
149. Costs and activity for minor injuries units (MIU) should only be reported separately if:
- (a) the MIU ward is discrete, and the attendance is instead of, and has not already been counted as, an emergency medicine attendance; or
  - (b) the MIU is not discrete but patients are seen independently of the main A&E department.
150. NHS walk in centres (national code 04) are defined as predominantly nurse-led primary care facilities dealing with illnesses and injuries - including infections and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or minor burns and strains - without the need to register or make an appointment. They are not designed for treating long-term conditions or immediately life-threatening problems.
151. A&E mental health liaison services should be reported as set out in paragraph 322 and not here.
152. The costs of activity typically unbundled should therefore be included within the core emergency medicine HRGs. The Grouper will determine a single HRG only for each A&E attendance record, irrespective of the presence of care elements that are unbundled from the core HRG when occurring in admitted patient or outpatient settings.
153. Patients brought in dead (A&E patient group code 70)<sup>50</sup> should be coded and costed against HRG VB99Z - Patient Dead on Arrival.

<sup>49</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/messages/cds\\_v6-2/data\\_sets/cds\\_v6-2\\_type\\_010\\_-\\_accident\\_and\\_emergency\\_cds\\_fr.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6-2/data_sets/cds_v6-2_type_010_-_accident_and_emergency_cds_fr.asp?shownav=1)

<sup>50</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/a/a\\_and\\_e\\_patient\\_group\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/a_and_e_patient_group_de.asp?shownav=1)

## Section 6: Unbundled services

### Introduction

154. This section covers unbundled HRGs for
- (a) chemotherapy,
  - (b) critical care,
  - (c) diagnostic imaging,
  - (d) high cost drugs,
  - (e) radiotherapy,
  - (f) rehabilitation, and
  - (g) specialist palliative care.
155. Unbundled HRGs for renal dialysis for acute kidney injury are covered separately in [Section 7](#).
156. Unbundled HRGs were developed to identify specialist services, ensure recognition of priority areas, support service redesign and patient choice, and improve the performance of HRGs so they better represent activity and costs.
157. Where there is a zero or minimal cost to be allocated against a core HRG (e.g. because a patient is admitted immediately to critical care or specialist palliative care and dies there), trusts may exclude the core HRG from their return and include all costs against the unbundled HRG.

### Chemotherapy

158. Patients receive a core HRG and one or more additional unbundled chemotherapy HRGs split into two categories:
- (a) HRGs for procurement of chemotherapy regimens according to cost band, or
  - (b) HRGs for the delivery of chemotherapy regimens.
159. The activity measure for the chemotherapy procurement HRGs is the number of cycles<sup>51</sup> of treatment and the unit cost is per average cycle.
160. Chemotherapy procurement HRGs are designed to cover the cost of the entire procurement service and therefore, in contrast to unbundled high cost drugs (paragraph 211), the cost of each HRG should include pharmacy oncosts (including indirect costs and overheads) as well as all other costs associated with procuring each drug cycle. The cost of supportive drugs on the single, national list of drugs funded through the Cancer Drugs Fund<sup>52</sup> should also be included within these HRGs.
161. The definitions in Table 9 may assist with costing of the chemotherapy delivery HRGs.

#### Table 9: Chemotherapy delivery

<sup>51</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/a/anti-cancer\\_drug\\_cycle\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/anti-cancer_drug_cycle_de.asp?shownav=1)

<sup>52</sup> <http://www.england.nhs.uk/ourwork/pe/cdf/>

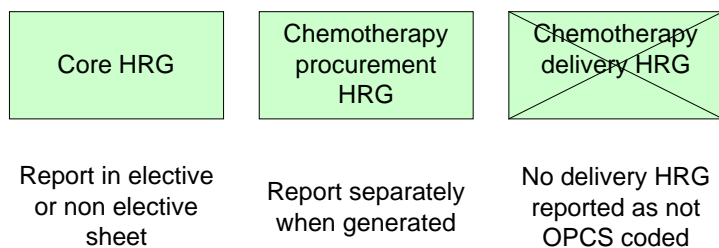
Definition	Explanation
Deliver simple parenteral chemotherapy	Overall time of 30 minutes nurse time and 30 to 60 minutes chair time for the delivery of a complete cycle.
Deliver more complex parenteral chemotherapy	Overall time of 60 minutes nurse time and up to 120 minutes chair time for the delivery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

162. In addition to these unbundled chemotherapy HRGs, there is a core HRG (SB97Z) for a same day chemotherapy admission or attendance that is generated by the Grouper if;
- Chemotherapy has taken place.
  - The activity has length of stay less than one day.
  - No major procedures have taken place and the core HRG which would otherwise be generated is diagnosis driven.
163. SB97Z attracts a zero national price to ensure appropriate overall reimbursement where a patient is admitted or attends solely for delivery of chemotherapy and no additional activity has taken place. SB97Z will be supplied with a mandatory zero cost in the collection workbook, and therefore trusts should include any notional costs against the unbundled chemotherapy delivery HRGs.
164. Supportive care costs for cancer patients receiving chemotherapy should be allocated according to the matching principle. Therefore,
- The costs of services directly related to the treatment of cancer, before and after surgery, should be allocated to the appropriate surgical HRG.
  - Supportive care costs not associated with the surgical procedure should be allocated to the appropriate non-surgical cancer HRG which, if this is SB97Z, would be the unbundled chemotherapy delivery HRG.
165. Chemotherapy should be reported in the following categories to reflect differences in clinical coding guidance between these settings:
- ordinary elective or non-elective admissions,
  - day case and regular day or night attendances,
  - outpatients, or
  - other.

### Ordinary admissions

166. The reporting of ordinary elective or non-elective admissions should include the core HRG and the relevant chemotherapy procurement HRGs where generated. Chemotherapy delivery HRGs will not be generated because OPCS chemotherapy delivery codes are not recorded for ordinary admissions (Figure 1). The ability to deliver chemotherapy is expected to be part of the routine care delivered on a ward, and therefore costs should be reported as an overhead to the core HRG.

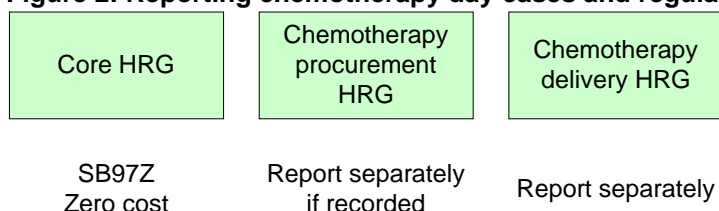
**Figure 1: Reporting chemotherapy ordinary admissions**



### Day case and regular day or night admissions

167. The reporting of day cases and regular day or night admissions solely for the delivery of chemotherapy should include an unbundled chemotherapy delivery HRG, and may include an unbundled chemotherapy procurement HRG where the procurement of a cycle is recorded. The core HRG SB97Z will be generated for patients admitted for same day chemotherapy treatment if no other significant procedure has taken place (Figure 2).

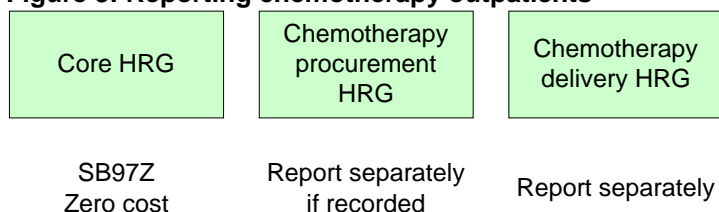
**Figure 2: Reporting chemotherapy day cases and regular day or night attenders**



### Outpatients

168. Outpatients attending solely for the delivery of chemotherapy should be reported as an unbundled chemotherapy delivery HRG, and may be reported as an unbundled chemotherapy procurement HRG where the procurement of a cycle is recorded. The core HRG SB97Z will also be generated for patients attending for same day chemotherapy treatment (Figure 3).

**Figure 3: Reporting chemotherapy outpatients**



### Other settings

169. This other category (which we have also provided for diagnostic imaging, high cost drugs, radiotherapy, rehabilitation and specialist care) recognises that unbundled HRGs are setting independent. It should be used where the service is delivered outside hospital. It must not be used to misreport admitted patient care or outpatient care due to miscoding or software issues.

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



## Additional guidance on chemotherapy

171. Although rare, some patients may have two regimens delivered at one attendance which results in two delivery HRGs. An example is a patient receiving an intrathecal component of a regimen where this component will generate a separate procurement and delivery alongside any other regimen they may be receiving.
172. Further guidance relating to the treatment of regimens not on the national list can be found in the OPCS-4 clinical coding instruction manual<sup>53</sup>.
173. Patients receiving both an infusion plus oral treatment as part of a single regimen on the same day will be counted as one delivery and coded to an intravenous delivery code. Patients may also receive other intravenous and oral drugs for their cancers on the same day as their chemotherapy regimen, e.g. administration of bisphosphonates. The costs of these should be attributed to the relevant core HRG and not included with the chemotherapy delivery HRG.
174. To maintain consistency with national coding guidance, the OPCS procurement and delivery codes for chemotherapy should only be used where the treatment is for systemic anti-cancer therapy, i.e. malignancy and not for the treatment of non-malignant conditions. Certain drugs appear in both the chemotherapy regimens list and high cost drugs list as they can be used to treat neoplasms as well as a range of other non-neoplastic conditions for example rheumatology. These should be coded using the OPCS high cost drugs codes and not the OPCS procurement and delivery codes.
175. Current clinical coding guidance stipulates when to code delivery of oral chemotherapy (SB11Z). If a regimen includes oral and parenteral administration, the parenteral administration determines the delivery code. SB11Z will be assigned to regimens made up of only drugs administered orally and the costs should reflect current practice in light of recommendations within the National Patient Safety Agency (NPSA) report on oral chemotherapy<sup>54</sup>.
176. We are aware that some supportive drugs may have a disproportionately high cost compared to the other expected costs of care within the unbundled chemotherapy procurement HRG, and that some hormonal drugs may similarly have a disproportionately high cost within the core HRG.
177. However, the cost of supportive drugs – which are any drugs given to prevent, control, or relieve complications and side effects and to improve the patient's comfort and quality of life - should also be included within these HRGs as per Table 10.

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<http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/publications/ccim>

<sup>54</sup> <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59880>



**Table 10: Supportive and hormonal drug treatment**

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

## Critical care

178. Critical care reference costs are collected separately for

- (a) adult critical care,
- (b) paediatric critical care, and
- (c) neonatal critical care.

### Adult critical care

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

180. Adult critical care HRGs are based on the total number of organs supported in a critical care period. The CCMDS (ISB 0153/Amd 81/2010<sup>55</sup> refers) collects a wider range of organ support information. Reference costs use these organ support categories to classify cost and activity data. The costs and activity for stays in critical care should therefore be excluded from the composite cost and length of stay for the admitted patient care and a separate cost per bed day produced.

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

182. Reference costs for adult critical care are differentiated by all critical care unit functions<sup>56</sup> in the CCMDS:

- (a) 01 Non-specific, general adult critical care patients predominate
- (b) 02 Surgical adult patients (unspecified specialty)
- (c) 03 Medical adult patients (unspecified specialty)

<sup>55</sup> <http://www.isb.nhs.uk/library/standard/112>

<sup>56</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/c/cou/critical\\_care\\_unit\\_function\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cou/critical_care_unit_function_de.asp?shownav=1)

- (d) 05 Neurosciences adult patients predominate
- (e) 06 Cardiac surgical adult patients predominate
- (f) 07 Thoracic surgical adult patients predominate
- (g) 08 Burns and plastic surgery adult patients predominate
- (h) 09 Spinal adult patients predominate
- (i) 10 Renal adult patients predominate
- (j) 11 Liver adult patients predominate
- (k) 12 Obstetric and gynaecology critical care patients predominate
- (l) 90 Non-standard location using a ward area
- (m) 91 Non-standard location using the operating department.

183. Trusts that cannot differentiate their costs should use national code 01.

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

185. Data for children treated in adult critical care units should be reported as part of its costs.

### Critical care periods

186. Record the number of critical care periods<sup>57</sup> that have occurred within each hospital spell. A critical care period is a continuous period of care or assessment (i.e. a period of time) within a hospital provider spell during which a patient receives critical care in any one single unit function type of the critical care unit. A new critical care period commences with each new CCMDS record.

187. Discrepancies can arise when counting critical care bed days for all types of critical care services activity. For reference costs, counting of adult, neonatal or paediatric critical care should follow the example in Table 11.

**Table 11: Critical care bed day count**

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

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

### Costing critical care

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

- (a) Medical staff.
- (b) Nursing and other clinical staff.
- (c) Therapies.
- (d) Ward consumables.

<sup>57</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/classes/c/critical\\_care\\_period\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/classes/c/critical_care_period_de.asp?shownav=1)

- (e) Drugs.
- (f) Blood and blood products.
- (g) Diagnostics undertaken whilst the patient is in critical care.
- (h) Medical and surgical equipment.

190. The costs of any theatre time must be reported against the core HRG and not the unbundled critical care HRG. If a patient's TFC changes on admission to a critical care unit, a new FCE will begin, and theatre costs will not form part of the total cost for the critical care service. But even if a new FCE does not start on admission to critical care or an FCE is wholly within critical care under a critical care consultant from admission to discharge theatre costs should still be excluded from critical care, and reported against the core HRG.
191. Where there is no theatre time, this may result in a relatively small or even zero cost against the core HRG. In these circumstances, trusts have the discretion to exclude these zero cost HRGs on the same principle that other zero cost HRG are excluded (paragraph 49). The key principle here is that critical care represents the highest level of complexity and only the daily costs of providing critical care should be recorded against the unbundled critical care HRG. Meanwhile, costs relating to treating the patient's condition, including any surgery or theatre irrespective of setting, should be reported against the core HRG.
192. The costs of relevant high cost drugs or high cost blood products should be included in the unbundled high cost drugs HRGs (paragraph 208) and not here.
193. Many trusts have adult critical care outreach teams that operate outside the parameters of the discrete adult critical care unit. Outreach teams support general ward staff in caring for higher acuity patients, facilitate admission to and discharge from critical care, help avoid unnecessary critical care admissions, share clinical skills, and follow up patients to monitor outcomes and services. Trusts should include outreach teams as an overhead to admitted patient care, and not report them as a separate total cost.

### Paediatric critical care

194. Costs should be reported against the following unbundled HRGs, which are supported by the paediatric critical care minimum dataset (PCCMDS)<sup>58</sup> and further qualified in terms of scope on page 2 of DSCN 01/2007 version 3<sup>59</sup>:

XB01Z - solely for use for extra corporeal membrane oxygenation (ECMO) or extra corporeal life support (ECLS) within a designated provider and nationally commissioned. The providers in Table 12 are expected to report the majority of costs.

**Table 12: Providers of ECMO, ECLS or aortic balloon pump**

Code	Name
RBS	Alder Hey Children's NHS Foundation Trust

<sup>58</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/messages/supporting\\_data\\_sets/data\\_sets/paediatric\\_critical\\_care\\_minimum\\_data\\_set\\_fr.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/messages/supporting_data_sets/data_sets/paediatric_critical_care_minimum_data_set_fr.asp?shownav=1)

<sup>59</sup> <http://www.isb.nhs.uk/documents/dscn/dscn2007>

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

XB02Z to XB05Z - relate to intensive care. Only the providers in Table 13 with paediatric intensive care units (PICU) are expected to report costs. Children in an adult ICU with a CCMD5 rather than a PCCMD5 record have been incorrectly coded. Trusts should report these costs against UZ01Z, not sub-chapter XB, and arrange to correct their coding in future years.

**Table 13: Providers with paediatric intensive care units**

Code	Name
RBS	Alder Hey Children's NHS Foundation Trust
R1H	Barts Health NHS Trust
RQ3	Birmingham Children's Hospital NHS Foundation Trust
RGT	Cambridge University Hospitals NHS Foundation Trust
RW3	Central Manchester University Hospitals NHS Foundation Trust
RP4	Great Ormond Street Hospital for Children NHS Trust
RJ1	Guy's and St Thomas' NHS Foundation Trust
RWA	Hull and East Yorkshire Hospitals NHS Trust
RYJ	Imperial College Healthcare NHS Trust
RJZ	King's College Hospital NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RVJ	North Bristol NHS Trust
RX1	Nottingham University Hospitals NHS Trust
RTH	Oxford Radcliffe Hospitals NHS Trust
RT3	Royal Brompton and Harefield NHS Foundation Trust
RCU	Sheffield Children's NHS Foundation Trust
RTR	South Tees Hospitals NHS Foundation Trust
RHM	Southampton University Hospitals NHS Trust
RJ7	St George's Healthcare NHS Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
RJE	University Hospital of North Staffordshire NHS Trust
RA7	University Hospitals Bristol NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust

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

XB08Z - relates to paediatric critical care transport.

XB09Z - Paediatric Critical Care, Enhanced Care. Represents the resources involved in providing critical care to children where the critical care activity codes recorded do

not necessarily indicate high resource. Any provider may submit these costs.

195. The HRGs can be derived in a variety of settings. Therefore costs for delivery of critical care on children's wards, also known as non-discrete high dependency care, should be included and underpinned by the completion of a PCCMDS record. Care should be taken to ensure these costs are not double counted against the admitted patient care core HRG.
196. Unit costs for XB01Z to XB07Z and XB09Z are per occupied bed day (applying the counting convention in paragraphs 187 and 188), with each occupied bed day producing an HRG (i.e. one HRG per day).
197. Unit costs for XB08Z are per patient journey.
198. In 2006, the Casemix Service analysed the results of an observational costing study of staff resource costs in 10 PICU. The work is discussed in the *National report of the Paediatric Intensive Care Audit Network (PICANET), January 2004 – December 2006*<sup>60</sup>. The relative staff resource costs across HRGs arising from this work, and a worked example of how trusts might use these to benchmark their own reference costs returns before submission, are shown in Table 14, where we assume a hypothetical paediatric intensive care unit is delivering 5,000 bed days of activity a year at a cost of £10 million. The staff resource costs are expressed as a cost ratio with XB05Z as the reference HRG with a value of 1.00.

**Table 14: Using benchmark cost ratios to inform paediatric critical care reference costs**

		A	B	C = A * B	D = C / Sum C * £10 million	E = D/B
HRG	Description	Cost ratio	Bed days	Weighted bed days	Total cost of weighted bed days £	Average unit cost per bed day £
XB01Z	Paediatric Critical Care, Advanced Critical Care 5	<b>3.06</b>	100	306	546,233	5,462
XB02Z	Paediatric Critical Care, Advanced Critical Care 4	<b>2.12</b>	150	318	567,654	3,784
XB03Z	Paediatric Critical Care, Advanced Critical Care 3	<b>1.40</b>	500	700	1,249,554	2,499
XB04Z	Paediatric Critical Care, Advanced Critical Care 2	<b>1.22</b>	1,000	1,220	2,177,794	2,178
XB05Z	Paediatric Critical Care, Advanced Critical Care 1	<b>1.00</b>	2,000	2,000	3,570,154	1,785
XB06Z	Paediatric Critical Care, Intermediate Critical Care	<b>0.91</b>	750	683	1,219,207	1,626
XB07Z	Paediatric Critical Care, Basic Critical Care	<b>0.75</b>	500	375	669,404	1,339
			5,000	5,602	10,000,000	

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

<sup>60</sup> [http://www.picanet.org.uk/Audit/Annual-Reporting/Annual-Report-Archive/PICANet\\_National\\_Report\\_2007.pdf](http://www.picanet.org.uk/Audit/Annual-Reporting/Annual-Report-Archive/PICANet_National_Report_2007.pdf)

## Neonatal intensive care

200. Unit costs for XA01Z to XA05Z should be reported on per occupied bed day basis, with each occupied bed day (applying the counting convention in paragraphs 187 and 188) producing an HRG (i.e. one HRG per day).
201. XA06Z relates to neonatal critical care transport. The unit cost is per patient journey.

## Diagnostic imaging

202. Diagnostic imaging should be reported separately when occurring in the following settings:
- (a) outpatients,
  - (b) direct access, or
  - (c) other.
203. Diagnostic imaging should not be reported separately when occurring in admitted patient care. Its costs should be included within the core HRG, and any unbundled diagnostic imaging HRGs produced by the Grouper should be ignored. Similarly, the costs of diagnostic imaging in critical care, rehabilitation or specialist palliative care should be included in the unbundled critical care, rehabilitation or specialist palliative care HRG.
204. Some diagnostic imaging is not coded in a way that generates an unbundled diagnostic imaging HRG. For example, a correctly coded obstetric ultrasound in outpatients is likely to group to one of the obstetric medicine core HRGs (paragraph 132). Costs and activity for these scans should not be unbundled, but reported within the generated core HRG.
205. Plain film x-rays do not have an unbundled HRG. When occurring in admitted patient or outpatient settings, their costs should be included in the core HRG. When directly accessed, they should be reported separately as set out in paragraph 262.
206. Diagnostic imaging should also be reported by the TFC of the outpatient clinic in which the imaging was requested. Trusts should use code 999 if they are unable to assign a TFC accurately.
207. The unit cost is per examination.

## High cost drugs

208. Not all drugs that are high cost have an OPCS code, and therefore an unbundled high cost drug HRG. We discuss these in paragraph 498.
209. Drugs that do have an OPCS code will generate a separate unbundled high cost drug HRG in addition to the core HRG for the care episode. Where multiple high cost drugs are recorded, multiple high cost drug HRGs will be generated. For reference costs, high cost drugs should be reported separately as follows:



- (a) Admitted patient care - unit cost per spell. The OPCS-4 clinical coding instruction manual<sup>61</sup> states that high cost drugs are coded per hospital provider spell and not FCE, and usually assigned in the first episode where the drug is administered.
  - (b) Outpatients - unit cost per attendance.
  - (c) Other settings – unit cost per attendance. For other activity outside admitted, outpatient or direct access settings, the stand alone pharmacy data system should be used in the absence of clinical coding to derive the appropriate OPCS-4 code and thus generate the HRG.
210. The current HRG4+ design does not consider dosage. Taking this, and the coding guidance above into consideration, and to ensure that costs and activity are recorded consistently, the average cost of a high cost drug should be identified across the admitted patient spell or outpatient attendance.
211. The costs of each unbundled HRG should include only the actual costs of the drug. All other pharmacy oncosts, and the costs of drugs administered with high cost drugs, should remain in the core HRG.

## Radiotherapy

212. The unbundled radiotherapy HRGs are similar to the design of the unbundled chemotherapy HRGs, in that an attendance may result in an additional two HRGs: one HRG for pre-treatment planning and one HRG for radiotherapy treatment. The radiotherapy dataset should be used as a source of data for submitting reference costs. This will result in the vast majority of activity reported as outpatient attendances, although the collection offers the following settings for consistency:
- (a) Ordinary elective or non-elective admissions.
  - (b) Day case and regular day or night attendances.
  - (c) Outpatients.
  - (d) Other.
213. In addition to these HRGs, a core HRG (SC97Z) for a same day external beam radiotherapy admission or attendance is generated by the Grouper if:
- (a) external beam radiotherapy has taken place,
  - (b) the activity has length of stay less than one day, or
  - (c) no major procedures have taken place and the core HRG which would otherwise be generated is diagnosis driven.
214. The same principles described in paragraph 163 for SB97Z also apply to SC97Z.
215. Activity should be allocated for each fraction of radiotherapy delivered and only one fraction per attendance should be coded. The intention in HRG4+ is that each fraction would be separately counted, rather than the number of courses of treatments. However, clinical coding guidance states that only one delivery fraction

61

<http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/publications/ccim>



should be recorded per stay.

216. Therefore, the unit of activity for ordinary admissions is per admission, unless the patient has treatment to more than one body site when it would be permissible to record a delivery fraction for each area treated if a change in resources was identified from delivery on a single site. This will not be an issue for activity recorded in the radiotherapy dataset as outpatient. Table 15 clarifies the Grouper output for different patient settings (providing trusts have followed coding guidance) and the treatment of the data for reference costs.

**Table 15: Radiotherapy outputs**

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

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

218. An average unit cost per treatment course should not be reported for delivery costs in day case, regular day or night attendance, or outpatient settings. Instead, cost per fraction should be reported by HRG.

219. Supportive care costs for cancer patients receiving radiotherapy in an ordinary elective or non-elective setting should be allocated as set out in paragraph 164.

220. Advice from the National Cancer Action Team (NCAT)<sup>62</sup> highlights the need to allocate costs according to the type of radiotherapy being delivered. There are predominantly two types of radiotherapy:

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

221. Work to develop the brachytherapy classification is ongoing. Until this work is

<sup>62</sup> <http://webarchive.nationalarchives.gov.uk/20130513211237/http://www.ncat.nhs.uk/>

complete, it is important that brachytherapy costs are only reported within the current set of brachytherapy HRGs, and not within the external beam HRGs.

## Rehabilitation

222. For the purposes of reference costs, rehabilitation is provided to enable a patient to improve their health status, and involves the patient actively receiving medical attention. Rehabilitation for patients with mental health conditions should be reported under [Section 9](#) and not here.
223. Unbundled rehabilitation HRGs are only generated where care is identified as taking place under a specialist rehabilitation consultant or within a discrete rehabilitation unit.
224. The Grouper will output an unbundled rehabilitation HRG for discrete rehabilitation accompanied by a multiplier showing the days of rehabilitation within the FCE, and adjust the core length of stay for this activity. Figure 4 illustrates the Grouper output and the reporting requirements for reference costs.

**Figure 4: Reporting rehabilitation services**

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?

One core HRG (reported in ordinary admission worksheet)	20 unbundled HRGs (reported in rehabilitation worksheet)
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What costs should be reported and where?

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

225. Rehabilitation should be reported under the following settings:

- admitted patient care – unit cost per occupied bed day,
- outpatient – unit cost per attendance, or
- other.

226. Each setting is further divided as follows:

- complex specialised rehabilitation services level 1,
- specialist rehabilitation services level 2, or
- non-specialist rehabilitation services level 3.

### Complex specialised rehabilitation services

227. Certain aspects of rehabilitative care are delivered by specialist NHS providers. Associated with the delivery of complex specialised and specialist rehabilitation are an expectation of increased resource usage and longer durations of admitted patient

care. To report the activity and costs of these as part of composite discrete rehabilitation would be to mask the extent of the resources used. Therefore, to support the definitions of specialised services in the SSNDS<sup>63</sup>, the collection requires that the NHS separately identify not only those complex specialised rehabilitations services, but also those that might be termed specialist.

228. CSRS that fall within this definition set and contain components relating to admitted patient rehabilitation are:
- (a) specialised spinal services (all ages),
  - (b) specialised rehabilitation services for brain injury and complex disability (adult),
  - (c) specialised burn care services (all ages), or
  - (d) specialised pain management services (adult).

### Specialist rehabilitation services

229. A specialist rehabilitation service (SRS) level 2 is one that is not designated a CSRS level 1 service but has the following characteristics:
- (a) A co-ordinated multi-disciplinary team of staff with specialist training and experience, including a consultant with specialist accreditation in the specific area of rehabilitation.
  - (b) Carries a more complex caseload, as defined by agreed criteria.
  - (c) Meets the national standards for specialist rehabilitation laid by the appropriate royal college and specialist societies, e.g. the British Society of Rehabilitation Medicine (BSRM) for amputee musculoskeletal and neurological rehabilitation (including stroke and brain injury rehabilitation).
  - (d) Serves a recognised role in education, training and published research for development of specialist rehabilitation in the field.
230. The BSRM have developed criteria and checklists for the identification of these level 2 services that conform to the standards required of a specialist rehabilitation service, which may be applied through a scheme of peer review and benchmarking of reported data to confirm service quality.

### Non-specialist rehabilitation services

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

<sup>63</sup> <http://www.hscic.gov.uk/casemix/prescribedspecialisedservices>

## Costing rehabilitation services

232. Rehabilitation should only be separately identified where discrete rehabilitation has been carried out. No attempt should be made to separately identify non-discrete rehabilitation costs during an admitted patient care stay.
233. Increasingly, rehabilitation services are provided by community hospitals following transfer from an acute provider. Community hospitals should note the following:
- Community hospitals providing a rehabilitation service should report this on an occupied bed day basis by HRG.
  - 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, trusts 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.
234. Unbundled rehabilitation HRGs should not be used to describe the cost of activity beyond an HRG trim point for any acute or non-specified HRG. This should still be reported as excess bed days.

## Specialist palliative care

235. The unbundled specialist palliative care HRGs should be reported against the following settings:
- ordinary elective or non-elective admissions, including support hospital teams,
  - day cases and regular day or night admissions,
  - outpatients, or
  - other.
236. The unbundled HRGs include care that is provided under the principal clinical management of a specialist palliative care medicine consultant, either in a palliative care unit or in a designated palliative care programme. This care should usually be reported using main specialty codes for palliative medicine (315), nursing episode (950) or allied health professional episode (960).
237. Bereavement counselling should only be included in specialist palliative care or other HRGs in the unusual circumstance it is provided directly to the patient or, where the patient is a child, to the carer as a proxy to the child. In all other situations, it should be treated as an overhead.

## Ordinary admissions

238. Specialist palliative care for ordinary elective or non-elective admissions should be reported per bed day using HRG SD01\*. The Grouper will output an unbundled specialist palliative care HRG accompanied by a multiplier showing the days of specialist palliative care within the FCE, and adjust the core length of stay for this activity.
239. If a patient is not admitted under the care of a specialist palliative medicine consultant but is receiving support from a member of a specialist palliative care team, this is classed as specialist palliative care support and should be reported per bed day using HRG SD03\*. The core HRG length of stay should not be adjusted for specialist palliative care support.

## Day case and regular day or night attenders

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

## Outpatients

241. For non-admitted care, HRG SD04\* should be reported for medical and HRG SD05\* for non-medical specialist palliative care attendances. A core outpatient attendance HRG should not also be reported when a patient attends for specialist palliative care only.

## Section 7: Renal dialysis

### Introduction

242. This section covers renal dialysis for chronic kidney disease and acute kidney injury.

### Renal dialysis for chronic kidney disease

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

244. When a patient has dialysis for chronic kidney disease, some trusts record a dialysis session (patient solely admitted for dialysis) as an outpatient or regular day admission within the CDS. This should generate the sub-chapter LD HRG for the dialysis (against which all costs should be reported), and a core HRG of LA97A or LA97B (which we have excluded from the workbook) for the CDS activity.

### Haemodialysis

245. HRGs LD01\* to LD10\* describe chronic kidney disease haemodialysis. The unit cost is per individual session, i.e. each session of haemodialysis treatment received on a given day for each patient.

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

247. 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.

248. There is an additional requirement to:

- (a) Identify separately the costs and activity associated with providing haemodialysis to patients aged 19 years and over whilst they are away from their normal base. This will help ensure that national prices differentiate appropriately between the costs of dialysis away from base and at the patient's normal base. Trusts will need to liaise with their renal unit to obtain this information. Costs should be provided on exactly the same basis as for regular dialysis at the base unit.
- (b) Report as memorandum information the average number of sessions per week per patient of home haemodialysis for patients aged 19 years and over. Trusts will need to liaise with their renal unit to obtain this information.

### Peritoneal dialysis

249. HRGs LD11\* to LD13\* HRGs describe peritoneal dialysis. The unit cost is per day as described in the NRD, and not per number of bags or exchanges. The cost of the

bags used for each session is a major cost driver. These bags can differ in size, so using number of bags is not a good proxy for number of sessions. Instead, patient days should be used as a proxy for sessions. The cost of the fluids for exchange, plus the operating costs of the machine facilitating the exchange in APD should be included.

## Renal dialysis for acute kidney injury

250. Renal dialysis for acute kidney injury is described by unbundled subchapter LE, containing HRGs split between haemodialysis and peritoneal dialysis for adults and children.
251. About one third of patients who receive dialysis for acute kidney injury have a primary diagnosis of acute kidney injury and generate a core HRG of LA07\*. The other two thirds of patients have other primary diagnoses and treatments, so the LE unbundled HRGs can be generated alongside any core HRG.
252. Each session of dialysis a patient has for acute kidney injury within admitted patient care will generate an unbundled HRG to which the costs associated with the dialysis should be assigned.

## Costing renal dialysis

253. Renal medicine admitted patient care costs should be mapped accordingly to admitted patient care cost pools and not to renal dialysis except where these costs are directly related to dialysis in admitted patient care. The full range of staffing inputs should be allocated to all dialysis modalities including, but not limited to, medical and nursing staff (including erythropoiesis stimulating agents (ESA) management), nutrition and dietetic staff, social work, pharmacy and medical engineering or technical staff. Costing models must allocate these appropriately to peritoneal dialysis therapies. Costs should also include the revenue costs of buying and maintaining buildings and equipment, allocated appropriately between the different types of dialysis.
254. Outpatient activities associated with each dialysis modality should be separately recorded and linked to the outpatient point of delivery e.g. pathology testing or drug prescriptions issued in clinics. The outpatient attendance HRGs should not be reported for patients attending for renal dialysis only
255. For dialysis undertaken using a hub and spoke configuration, the activity and costs should be recorded within the submission of the NHS provider with contractual responsibility for the delivery of the care.
256. The costs of all ESAs and drugs for bone mineral disorders should be included in the LD HRG costs. Some of these drugs should also be reported separately in the drugs and devices worksheet:
- (a) the ESAs Epoetin alpha, beta and zeta, and Darbetin alpha
  - (b) the drugs for bone mineral disorders Cincalcet, Sevelamer and Lanthanum.
257. Patients sometimes required drugs related to associated conditions. These drug



costs should be treated as any other cost of treatment and attributed at the point of delivery, or the point of commitment in outpatients, unless separately identified.

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

## Section 8: Direct access services

### Introduction

259. This section covers the following direct access services<sup>64</sup>

- (a) diagnostic services, and
- (b) pathology services.

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

### Diagnostic services

261. Patients can directly access a range of diagnostic services, including physiological and clinical measurement tests. These are identifiable in CDS release 6.2 through the direct access referral indicator field<sup>65</sup>, and trusts should report them using the relevant HRGs.

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

### Pathology services

263. Costs and activity for the following pathology services should be submitted based on the number of tests, with the number of requests for pathology investigation<sup>66</sup> required as a memorandum:

- (a) Cytology (excluding cervical screening programmes).
- (b) Histopathology and histology.
- (c) Integrated blood sciences services (including clinical biochemistry, haematology and immunology).
- (d) Clinical biochemistry.
- (e) Haematology.
- (f) Immunology.
- (g) Microbiology (including bacteriology, virology and mycology).

<sup>64</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/d/direct\\_access\\_service\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/direct_access_service_de.asp?shownav=1)

<sup>65</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/d/den/direct\\_access\\_referral\\_indicator\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/d/den/direct_access_referral_indicator_de.asp?shownav=1)

<sup>66</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/r/request\\_for\\_pathology\\_investigation\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/r/request_for_pathology_investigation_de.asp?shownav=1)

- (h) Phlebotomy.
- (i) Other.

264. Trusts may submit costs against integrated blood sciences, or separately against clinical biochemistry, haematology and immunology, but must not submit costs against both.
265. Trusts should refer to the National Laboratory Medicine Catalogue, a catalogue of pathology tests designed to support consistent, standardised reporting, which is available via TRUD (paragraph 3).
266. The Department, working with NHS Midlands and East, has also produced a toolkit to support commissioning of community (i.e. direct access) pathology services<sup>67</sup>. Whilst primarily intended for commissioners, providers of pathology services may also find some of the tools helpful.
267. Direct access pathology costs will vary depending on whether the service is hospital or community based. Care should be taken to include the entire cost, including costs incurred in the transportation of samples where appropriate.

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<sup>67</sup> <https://www.gov.uk/government/news/toolkit-for-commissioning-of-pathology-services>

## Section 9: Mental health services

### Introduction

268. This section covers:

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

269. Mental health trusts should also use currencies described elsewhere in this guidance for services not described here. For example, forensic psychiatry outpatients should be reported against TFC 712, as described in [Section 4](#).

270. The currencies for most mental health services for working age adults and older people are mental health care clusters. Care clusters were mandated for use from April 2012 by the Department, and this guidance should be read alongside Monitor and NHS England's "Guidance and Mental Health Currencies and payment" document<sup>68</sup>.

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

272. Table 16 summarises the allocation of mental health services across the reference cost currencies.

**Table 16: Allocation of mental health services within reference costs**

Service	Included in cluster reference costs	Included in non-cluster reference costs	Excluded from reference costs
Approved social worker services*	Yes		
Assertive outreach teams	Yes		
Counselling and therapy***	Yes	Yes	
Crisis accommodation services	Yes		
Carer support services (if costs cannot be separately allocated to individual patients this cost should be treated as an overhead)	Yes		
Crisis resolution and home treatment teams	Yes		
Early intervention in psychosis services from age 14	Yes		
Eating disorder services (adult, excluding specialised eating disorders)	Yes		
Emergency clinics or walk in clinics	Yes		
Emergency duty teams (which are not emergency assessments e.g. for sectioning under the Mental Health Act)*	Yes		
Homeless mental health services	Yes		
Local psychiatric intensive care units	Yes		

68

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300864/Guidance\\_to\\_mental\\_health\\_currencies\\_and\\_payment.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300864/Guidance_to_mental_health_currencies_and_payment.pdf)

Service	Included in cluster reference costs	Included in non-cluster reference costs	Excluded from reference costs
Psychology ***	Yes	Yes	
Psychotherapy ***	Yes	Yes	
Psychiatric liaison services including A&E liaison, Acute hospital Liaison, Nursing home Liaison etc.		Yes	
Adult specialist eating disorder services		Yes	
Autism and Asperger syndrome		Yes	
CAMHS		Yes	
Drug and alcohol services		Yes	
Eating disorder services (children and adolescents)		Yes	
Forensic and secure mental health services - Inpatients		Yes	
Forensic outpatients		Yes	
Gender identity disorder services		Yes	
Improving access to psychological therapies (IAPT)		Yes	
Learning disability services in high dependency or high secure units		Yes	
Mental health service for Deaf children and adolescents		Yes	
Mental health services for military veterans		Yes	
Mental health services provided under a GP contract		Yes	
Perinatal mental health services (mother and baby units)		Yes	
Primary diagnosis of drug or alcohol misuse		Yes	
Specialised addiction services		Yes	
Specialist mental health services for Deaf adults		Yes	
Specialist psychological therapies (admitted patients and specialised outpatients)		Yes	
Acquired brain injury			Yes
Learning disability services not provided in high dependency or high secure units			Yes
Neuropsychiatry			Yes

\* these services are only included in clusters where NHS funded, otherwise they are excluded.

\*\* other specialist teams.

\*\*\* Where the service is provided to a clustered user, the cost is included in the cluster. Where the service is provided to a non-clustered user, the cost is included in a non-cluster currency (paragraph 267).

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

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

## Adult mental health services

### Mental health care clusters

274. The mental health care clusters<sup>69</sup> for working age adults and older people, focus on the characteristics and needs of a service user under three broad diagnostic categories of organic, psychotic and non-psychotic, rather than the individual interventions they receive or their specific diagnosis. The care clusters are numbered from 00-21, although 09 is not currently used and 99 is used for patients not assessed or clustered.
275. In 2014-15 we are also introducing a further cluster category for initial assessments only. Cluster code IA98 is to be used for patients where an initial assessment has been completed but a patient has not been accepted into services for treatment. The introduction of this category will enable providers to separate unfinished assessment episodes (WIP) from assessments ending in discharge of the patient back to the GP or to another more appropriate treatment provider.
276. Mental health professionals code service users using the mental health clustering tool (MHCT) which helps them determine which cluster best describes the characteristics of a particular service user.
277. The MHCT and Mental health clustering tool booklet<sup>70</sup> must be used by providers. The clustering tool must be used to help inform the clustering decision, and the information that is captured must be returned along with other data as part of the monthly submission to the Mental health minimum dataset (MHMDS).
278. The clusters cover extended time periods which will often contain multiple different care interventions. For instance, whilst in cluster 3 (non-psychotic (moderate severity)) a service user might have several sessions of psychological therapies, contacts with a care coordinator and a prescription for exercise. Each cluster has an associated review period, defined as the time between reassessments, which should be taken as a **maximum rather than a minimum** period duration. However, if there is a re-assessment before the maximum review period, because of a change in their condition, this becomes the actual cluster review period for that patient.
279. Table 17 shows the clusters and their maximum review period.

**Table 17: Mental health care clusters**

Code	Cluster label	Cluster Review period (maximum)
00	Variance - Unable to assign mental health care cluster code	6 months
01	Common mental health problems (low severity)	12 weeks
02	Common mental health problems (low severity with greater need)	15 weeks
03	Non-psychotic (moderate severity)	6 months
04	Non-psychotic (severe)	6 months
05	Non-psychotic (very severe)	6 months
06	Non-psychotic disorders of over-valued ideas	6 months
07	Enduring non-psychotic disorders (high disability)	Annual

<sup>69</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/m/mental\\_health\\_care\\_cluster\\_d\\_e.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_care_cluster_d_e.asp?shownav=1)

<sup>70</sup> Annex 7C in the consultation documents published at <http://www.monitor.gov.uk/NT>

Code	Cluster label	Cluster Review period (maximum)
08	Non-psychotic chaotic and challenging disorders	Annual
09	Blank cluster <sup>71</sup>	Not applicable
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder (difficult to engage)	6 months
18	Cognitive impairment (low need)	12 months
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical need or engagement)	6 months
IA98	Patient assessed but not accepted into service	N/A
99	Patients not assessed or clustered	N/A

### Costing the mental health care clusters

280. Mental health providers should cost their services to the same costing principles set out in *Approved Costing Guidance* that apply to all NHS providers, and to the costing standards set out in the *HFMA Clinical Costing Standards for Mental Health*.
281. The key to costing accurately at cluster level is having the activity and interventions recorded by service user and the cluster assigned appropriately so costs can be built up by service user and then by cluster.
282. In line with the guidance for non-cluster mental health costs, the costs of teams providing activity to clustered service users should only include NHS funded staff. Where integrated community teams include social workers their costs and activity should only be included in the cluster costs if they are NHS funded posts.
283. The initial assessment period begins when a mental health trust receives a new referral from a GP or elsewhere. Experience to date suggests that this initial assessment will normally be completed within two contacts or on admission to an in-patient setting. The assessment is completed when the individual is either allocated to a cluster, or not allocated, for example discharged (cluster IA98).
284. Clusters in service code MHCC should only include costs and activity incurred for a service user who has been allocated to a cluster. Costs and days incurred prior to clustering will be allocated to the appropriate cluster in service code MHCCIA.
285. The worksheet includes separate lines for:
- Unable to assign mental health care cluster code (cluster 00) – record costs for a service user who has been assessed and accepted for treatment but has not been allocated a cluster, including the cost of their initial assessment on the

<sup>71</sup> Cluster 09 will not be available in the workbook



initial assessment worksheet.

- (b) Patients not clustered or assessed (cluster 99) - record costs incurred for treatment before a service user has been fully assessed and allocated to a cluster. This will include service user costs close to the year-end where the initial assessment costs fall into both years and the cluster is allocated after the year end. We do not want to include part year costs in initial assessments, so initial assessment costs before and after the year end will remain in cluster 99 in service code MHCCIA.
- (c) IA98 - Patient assessed but not accepted into service. This line should be used for patients where the assessment has been completed but the patient has been discharged without treatment. These may be inappropriate referrals into mental health services or referrals for a clinical opinion only.

286. Once a service user has been assessed and placed into a cluster, the cost of the initial assessment is coded to the correct cluster in service code MHCCIA, not MHCC.
287. The cost of re-assessment should be included in the cluster the user is assigned to, at the time of the re-assessment, rather than the new cluster if the cluster changes. Re-assessment that does not result in a change of cluster will be recorded as a new review period.
288. Patients who did not attend (DNA) are not collected separately. Therefore, the costs, but not the activity, associated with DNAs should be included as an overhead within the relevant cluster pathway. The same approach to DNAs applies to the non-cluster currencies.

### Mental Health Clusters

289. Due to the nature and length of mental health care clusters, with some beginning in one financial year and running to the next, and others having a length of 12 months or more, unit costs will be per cluster per day (produced using the length of clusters falling in the reference costs year, expressed in days, similar to an acute spell or episode, and the costs of interventions within them) not per completed cluster basis.
290. The non-cluster collection generally excludes activity which continues into the next reporting year (paragraph 37). To take account of the potential length of some of the mental health care clusters all activity and costs which occur in the financial year must be reported, regardless of whether the clusters have completed.
291. The clusters are designed to be setting independent. However, we will continue to collect initial assessments separately, and memorandum costs and activity for:
- (a) admitted patient care, and
  - (b) non-admitted patient care, covering outpatients, day care and community, and defined as the difference between the total number of cluster days and the number of cluster days in admitted patient care (i.e. if a patient is under the care of a community team and is then admitted to hospital, the days when the patient is an inpatient will count as occupied bed days and will not be included in the non-admitted patient days even though they may still be receiving visits from the community team). To avoid double counting each cluster day can only be counted in one location for that day.)

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

293. Table 18 summarises the data that we will collect for the mental health clusters.

**Table 18: Mental Health Care cluster worksheets**

Field	Comments
<b>Cluster costs (service code MHCC)</b>	
Unit cost per day per cluster	Average/weighted cost per day per service user per cluster. This is a calculated field, equal to:  (Unit cost per occupied bed day x Number of cluster days in admitted patient care + Unit cost per non-admitted cluster day x Number of cluster days in other settings) / Number of cluster days within the financial year
Number of cluster days within the financial year	Total number of patient days within each cluster within the financial year. This is a calculated field, equal to:  Number of cluster days in admitted patient care + Number of cluster days in other settings
<b>Memorandum information</b>	
Unit cost per occupied bed day	This covers admitted patient care on an occupied bed day basis covering ordinary elective and non-elective activity, including leave days.
Number of cluster days in admitted patient care	
Unit cost per non-admitted cluster day	This is the cost per day based on the number of days between the start and finish (or year-end) of the cluster review periods, when the service user was not in admitted patient care. It is not the number of contacts. Refer to the note in the row above if there is an overlap of care.
Number of cluster days in other settings	
Total number of completed cluster review periods	Total number of review periods in each cluster. If a service user has been allocated to a cluster more than once during the year, each separate time should be counted. A reassessment resulting in the service user remaining in the same cluster <b>does</b> result in a new review period. All review periods which complete during the year should be counted. Include review periods which started in the prior year and completed in the current year. Exclude review periods which started in the current year, but will not complete until next year.
Average review period (days)	Average length of a cluster review period. This is the average interval between review dates for each service user expressed in days. Only completed review periods should be included in the average calculation, part review periods at the beginning and end of the year should not be counted. Where there is an annual review period, record 365 here or actual length if available.
<b>Initial assessments (service code MHCCIA)</b>	
Unit cost per initial assessment	This covers the costs and activity associated with initial assessments of service users which helps clinicians to allocate them to clusters. Initial assessment and clustering of service users can require significant professional resource, and are therefore identified separately rather than included as an overhead for service users who are clustered.
Number of initial assessments	

## Days in the Cluster

294. The count of days in the cluster begins from the day that the patient is put onto a cluster and continues through to the date of the patient's discharge from services, or allocation to another cluster on review. Once a patient has been allocated to a cluster, any days where the patient is on a waiting list for treatment should be counted as cluster days.

295. The number of occupied bed days in the cluster includes days when an inpatient may

be on leave in the community. This is contrary to the guidance for non-cluster mental health activity in paragraph 305 which states that the leave beds should be excluded to the extent that it ensures that occupancies above 100% cannot be reported. As allocation of bed days to clusters should be based on patient level activity information, it would be impossible for most providers to identify which leave bed days should be excluded from the calculation at a cluster level, therefore all leave days are included in the calculation for this section of the return.

296. A significant number of providers have been unable to include the costs of community team's contact with inpatients into the inpatient quantum for clusters and this has given rise to inconsistencies in the reported costs per inpatient days. In order to restore consistency between providers, all trusts should now include the costs of community team's contacts with inpatients within the non-admitted cluster costs. As more trusts move to PLICs it should prove possible to identify this amount accurately and include it in the inpatient quantum in future collections.
297. The number of complete review periods and their average length should be returned in the memorandum columns. Where a review period is part completed during the year it should not be included. The intention is not to remove work in progress from the cluster cost and trusts must provide costs for the full period of care in the financial year. A review period for 12 months (clusters 07 to 13) is likely to cross two financial years, and should be reported as one review of 365 days unless the patient is discharged or changes cluster within the year in which case the actual length of time on the cluster ( since first cluster or last review) should be included.
298. Table 19 describes a service user who changes cluster. The service user is assessed and spends 28 days in cluster 14 at a cost of £10,000. They are reviewed and re-clustered to cluster 15, spending 20 days there at a cost of £8,000. They are re-reviewed and returned to cluster 14, where after being reviewed at 28 day intervals, spend the remaining 72 days until the end of the year at a cost of £40,000. The 16 days to the year-end are not counted as a review period or in the average review calculation.

**Table 19: Service user change of cluster**

Cluster	Total cost	Number of cluster days within the costing period	Unit cost per day per cluster	Total number of complete review periods	Average completed review period (days)
14	£50,000	28 + 28 + 28 + 16 = 100	£500	3	28
15	£8,000	20	£400	1	20

299. Table 20 describes a service user who is assessed multiple times in-year within a cluster. The service user is assessed as cluster 15 at a cost of £15,000 to the first review after 28 days and is confirmed to remain in cluster 15, where they spend 26 more days at a cost of £15,000. They are re-reviewed and stay in cluster 15, where they spend the remaining eight days until the end of the year at a cost of £1,000. There are two review periods, with an average review period of 27 days  $(26 + 28 / 2)$ . The eight days to the year-end are ignored.

**Table 20: Multiple assessment of service user**

Cluster	Total cost	Number of cluster days within the costing period	Unit cost per day per cluster	Total number of service review periods	Average review period (days)
15	£31,000	28+26+8=62	£500	2	27

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

## Child and adolescent mental health services

301. CAMHS should be reported in the following settings:

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

302. There are also sub-categories for:

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

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

## Drug and alcohol services

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

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

## Specialist mental health services

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

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

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

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

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

## Settings for non-cluster activity

### Ordinary elective and non-elective admissions

307. Costs and activity should be submitted by occupied bed day. Some admitted patient care within mental health services includes trial periods of time where patients are on home leave. They are not discharged but sent on leave to return as an admitted patient at a future date. This sometimes creates an anomaly where their beds may be used for other admitted patients, resulting in bed occupancy levels of over 100%.
308. Trusts should ensure that the reported total number of occupied bed days for a ward does not include any leave day activity unless the bed is held open for that patient to return to, i.e. that no other patient uses the bed in their absence. This rule also applies to patients transferred temporarily to an acute provider for treatment.
309. Where the PAS does not record home leave, the activity levels will need to be adjusted manually. The key rule is to ensure that multiple occupancy above 100% is not reported, as this would have the artificial effect of diluting the unit costs. Day care facilities
310. Costs and activity for mental health services provided in day care facilities<sup>72</sup> should be submitted on the same basis as for other patients using these facilities (paragraphs 361 to 363).
311. It is usually considered that day care facilities have consultant input and undertake patient assessments, whereas a community mental health team group contact would not necessarily involve a consultant and may not involve patient assessments.

### Outpatient attendances

312. Costs and activity should be reported for attendances and non face to face contacts. Where consultants have a clinical caseload within a specialist team, e.g. criminal justice liaison team, the costs and activity should be reported against the specialist team currencies (paragraph 320). Where consultants do not have a clinical caseload within a specialist team, costs and activity should be reported in an outpatient or community setting.

<sup>72</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/d/day\\_care\\_facility\\_de.asp?show\\_nav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?show_nav=1)

313. The key to determining whether activity should be reported in an outpatient or community setting is as follows:
- (a) if the appointment is booked into a clinic list for a specific clinic session, including clinics in a residential home, where a consultant sees more than one patient in that clinic and location, then report in an outpatient setting
  - (b) otherwise it should be reported in a community setting, e.g. a home or domiciliary visit or a visit to a single client in a residential home.
314. Primary consultations, e.g. telephone or informal contact, before the patient attends for a traditional first appointment (including mental health services such as CAMHS and community mental health teams) should not be recorded as an attendance. Rather, the cost of such contacts should form part of the unit costs of contacts with clients once accepted for treatment by the relevant service.
315. Domiciliary visit payments are now only paid in limited circumstances, or to those consultants who have chosen to retain the old consultant contract (section 12(2) 2003). The distinction to be made for reference costs is between:
- (a) a service user seeing a consultant in a clinic, which should be categorised as an outpatient attendance
  - (b) a consultant seeing a service user at home, which should be categorised as a community contact.

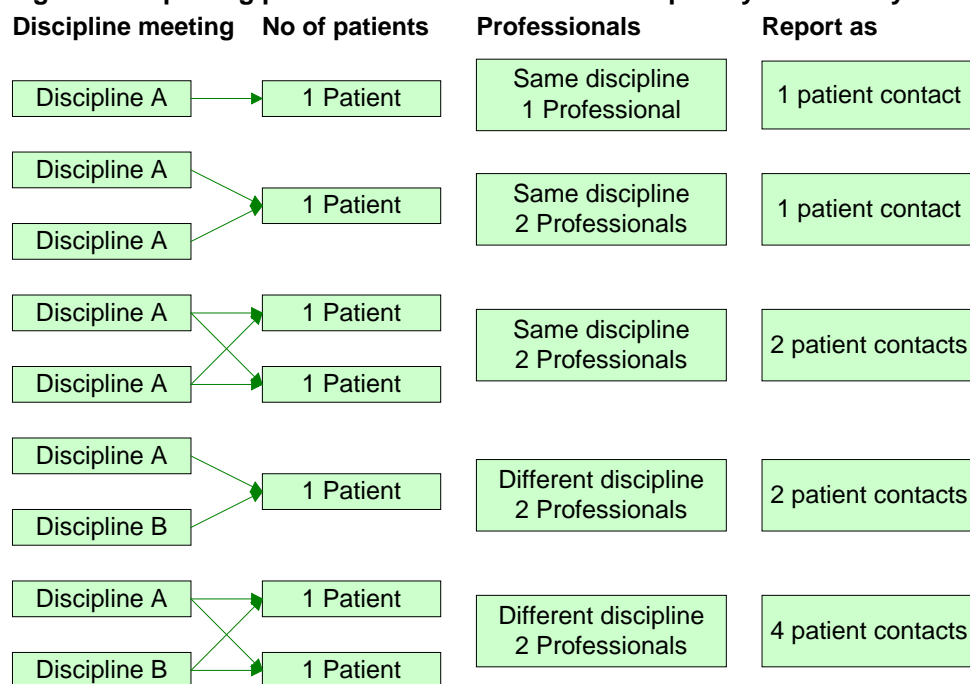
### Community contacts

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

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

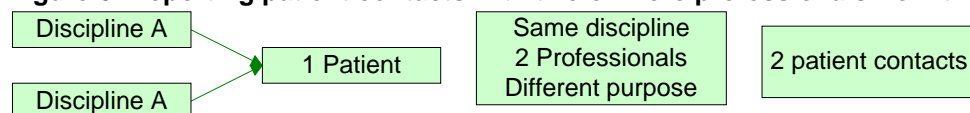
317. Figure 5 describes this process.

**Figure 5: Reporting patient contacts with multi-disciplinary community mental health teams**



318. The exception to this general principle is when two or more professionals from the same discipline meet a single patient, at the same time, but for a different purpose (Figure 6).

**Figure 6: Reporting patient contacts with two or more professionals from the same discipline**



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

### Mental health specialist teams

320. Most cost and activity data for services undertaken by mental health specialist teams (MHST), using currencies based on the annual national survey of investment in adult mental health services<sup>73</sup>, should now be included in the care clusters. Remaining costs and activity should be reported on a patient contacts basis for:

- A&E mental health liaison services.
- Psychiatric liaison – acute hospital/ Nursing Homes.
- Forensic liaison services.
- Other psychiatric liaison services.
- Criminal justice liaison.
- Forensic community.
- Psycho – sexual services.
- Prison health.

<sup>73</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/140098/FinMap2012-NatReportAdult-0308212.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/140098/FinMap2012-NatReportAdult-0308212.pdf)



- (i) Other mental health specialist teams.
- (j) IAPT (collected separately for adults and children)

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

# Section 10: Community services

## Introduction

322. This section covers:

- (a) allied health professionals
  - (i) dietician
  - (ii) occupational therapist
  - (iii) physiotherapist
  - (iv) podiatrist
  - (v) speech and language therapist
  - (vi) other therapist
- (b) audiology
- (c) day care facilities
- (d) health visiting and midwifery
  - (i) health visitors
  - (ii) midwives
  - (iii) parentcraft
- (e) intermediate care
  - (i) crisis response services
  - (ii) home based services
  - (iii) bed based services
- (f) medical and dental services
  - (i) community dental
  - (ii) community paediatric
- (g) nursing
  - (i) specialist nursing
  - (ii) district nurse
  - (iii) nursing services for children
  - (iv) school based children's health services
- (h) wheelchair services.
- (i) Community rehabilitation services

323. One of the challenges for reference costs for community services has been the lack of a standard minimum data set and detailed service descriptions for the majority of services commonly classified as community services. The introduction of the Community Information Data Set (CIDS)<sup>74</sup> for local implementation from April 2012, and full compliance by April 2015, therefore marks a significant step forward.

324. Until we reach the date for full compliance with the CIDS, recognising that not all community trusts have fully automated systems, trusts may use appropriate sample data to ascertain annual activity when reporting information in this section. There is no minimum sample time stipulated within reference costs but the sample should reflect annual activity in a service area. Where this is not feasible, trusts may use informed clinical estimates, retaining evidence of the data source.

325. Services described in this section may be provided in various locations and settings in the community, such as clinics, community hospitals, GP practices or health

<sup>74</sup> <http://www.ic.nhs.uk/comminfodataset>

centres. Home visiting will be required for some services. Others may be provided in acute hospitals. Where services are provided in an admitted patient care episode or outpatient attendance, the costs should be reported within the composite cost of the admitted patient care or outpatient attendance HRG. Otherwise, activity and costs for these services when provided in the community, including when directly accessed, should be reported in this section.

326. There is no information standard defining the difference between an outpatient attendance and a community care contact. Trusts should exercise their own judgement, but as a general rule of thumb a healthcare professional travelling to a community location to see just one patient should be treated as a community contact. Conversely where a clinician travels to a community location to see more than one patient in a planned session this should be treated as an outpatient attendance and reported in [Section 4](#).
327. As these services are delivered in a range of settings, input from other health professionals, including practice nurses will occur. All relevant costs have to be included to ensure comparability and the key principle is the cost of services and not the funding stream.
328. This section also applies to outreach services. These services reflect changes in the way health services are being delivered with less clearly defined boundaries around service delivery. For a number of services, this can result in the same staff delivering services in ward settings in acute hospitals and outside such settings to provide continuity of care to patients.

## Definitions

329. Unless otherwise stated for a particular service (e.g. wheelchair services), the activity measure used to derive a unit cost for all services in this section is the number of care contacts<sup>75</sup> within the reference costs year. The cost, but not the activity, of care contacts that were cancelled by either the provider or the patient or where the patient did not attend should also be included as an overhead.
330. This should include all face to face contacts with the patient, or a proxy such as a relative or carer e.g. the parent of a young child, where this is in lieu of a contact with the patient. Only activity that entails contact with the patient or proxy should be included.
331. Where both the patient and relative/carer are present this should be recorded as a patient contact. For example, it does not matter if a health visitor sees the parent, baby or both; this should be recorded as one contact.
332. Only non face to face contacts<sup>76</sup> that directly support diagnosis and care planning and replace a face to face contact should be included in the collection. Telephone contacts solely for informing patient of results are excluded.

<sup>75</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/classes/c/care\\_contact\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/classes/c/care_contact_de.asp?shownav=1)

<sup>76</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/c/cons/consultation\\_medium\\_used\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1)

333. Contacts about the patient but not involving the patient or their proxy should not be recorded as a care contact.
334. Group sessions –in previous collections we have used the number of sessions held as the activity measure, regardless of the number of patients attending the group, or the number of clinicians running the group. This is in contradiction to the counting of group sessions within the mental health collection where the activity measure is the number of patients attending the group and if two clinicians run the group, each clinician records a contact with each patient attending that group.
335. For 2014-15 therefore we propose to change the activity measure for group contacts so that it is consistent with the mental health collection.  
The activity measure for group sessions will therefore be the number of patients in the group. If 2 clinicians deliver a group session for 10 patients, each clinician will record 10 contacts for that group (total 20 contacts).
336. Twilight or evening services offered as an extension to a community nursing service should be reported under the appropriate category (e.g. district or specialist nursing).

## Allied health professionals

337. Reference costs in 2014-15 will cover the following allied health professionals (AHPs)<sup>77</sup>
- (a) dietician
  - (b) occupational therapist
  - (c) physiotherapist
  - (d) podiatrist
  - (e) speech and language therapist
  - (f) other therapist.
338. The other Therapist currency covers other care professional staff groups defined in the Data Dictionary: art therapist, drama therapist, music therapist. It also covers therapists in complementary or alternative medicine where these services are provided discretely.
339. Therapist services are further sub-divided into;
- (a) adult one-to-one,
  - (b) adult group, (unit of activity = no of patients attending the group as per paragraph 335)
  - (c) children one-to-one, or
  - (d) children group (unit of activity = no of patients attending the groups per paragraph 335).
340. The currencies for Podiatry services are described in Table 21.

**Table 21: Community podiatry currencies**

<sup>77</sup>

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/c/card/care\\_professional\\_staff\\_group\\_for\\_community\\_care\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/card/care_professional_staff_group_for_community_care_de.asp?shownav=1)

Currency	Description	Activity measure
Tier 1, General podiatry	Covers patients with low and medium levels of foot health need, in the absence of complicating disease such as diabetes <sup>78</sup> or rheumatoid arthritis <sup>79</sup> where foot health is identified in NICE guidelines as at risk. This includes painful nail pathologies, dermatological conditions, corns, calluses and fissures, heel pain and metatarsalgia, basic vascular assessments, falls prevention advice and foot health education.	Care contact
Tier 2, Minor surgery	Includes nail surgery procedures <sup>80</sup> to remove part of the nail or the whole nail to correct in-growing toe nails, or steroid injections to the foot or ankle, performed in community settings by podiatrists.	Procedure
Tier 3, Complex foot disease	Covers management of at risk foot and active foot disease in diabetes. Diabetic foot ulceration management including offloading devices and wound care, requiring senior staff, surgical debridement, costly dressings such as silver and maggots as well as off-loading air cast walkers, custom made orthotics and footwear. Increasingly, community foot protection teams supply antibiotics and generate costs for x-ray and pathology. Advanced management of rheumatoid arthritis using ultrasound and similar diagnostic techniques.	Care contact
Specialist Care 1	Clinical debridement using hydrojet devices and Topical Negative Pressure wound management for complex foot wounds.	Care contact
Specialist Care 2	Advanced vascular assessments. Specialist diagnostics are increasingly used by advanced vascular podiatrists to assess the whole limb for risk factors for cardiovascular disease, and incur costs that are significantly different to core podiatry.	Care contact
Other non-core podiatry	Any other podiatry services provided in community settings and not described above, including podiatric surgery, complex biomechanics, forensic podiatry.	Care contact

Podiatry services provided in an acute outpatient setting should be recorded on this worksheet using the more descriptive currencies above, and not on the OPATT worksheet.

Nail surgery procedures, performed by a podiatrist in an outpatient setting and grouping to JC43 HRGs, should be reported on the OPPPROC worksheet and not the OPPATT worksheet.

## Audiology

This section covers audiology attendances<sup>81</sup> and services delivered within discrete audiology departments, following referral from an ear, nose and throat (ENT) outpatient clinic or accessed directly.

341. There are two service codes for Audiology in the workbook as follows:

<sup>78</sup> <http://www.nice.org.uk/CG10>

<sup>79</sup> <http://www.nice.org.uk/CG79>

<sup>80</sup> The relevant OPCS-4 codes are S642, Chemical destruction of nail bed; S682, Excision of wedge of nail; S701, Avulsion of nail. Such procedures performed in admitted patient care or outpatient settings should already have been reported against HRG JC43A or JC43B, Minor Skin Procedures.

<sup>81</sup>

[http://www.datadictionary.nhs.uk/version2/data\\_dictionary/classes/a/amb/audiology\\_attendance\\_de.asp?sho](http://www.datadictionary.nhs.uk/version2/data_dictionary/classes/a/amb/audiology_attendance_de.asp?sho)

310 – Audiological medicine

840 - Audiology

## Assessment

342. The assessment HRG currencies are:

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

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

- (a) U241, Pure tone audiometry
- (b) U242, Balance assessment
- (c) U243, Hearing assessment
- (d) U248, Other specified diagnostic audiology
- (e) U249, Unspecified diagnostic audiology.

344. Trusts should report these costs as procedures in outpatients, as described in [Section 4](#).

345. The unit cost is per hearing assessment.

## Fitting

346. The fitting aid currencies are:

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

347. The unit cost is per fitting.

## Hearing aid

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

349. The hearing aid currencies are:

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

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

351. Costs of other repairs, moulds, tubes etc. should be included in the fitting or aftercare

services rather than against the actual hearing aid.

### Follow-up

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

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

### Aftercare

353. The aftercare currency covers costs associated with:

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

354. In addition, there are separate currencies to cover the maintenance and programming of bone anchored hearing aids (BAHA) and cochlear implant. These costs do not form part of the CA39\*, CA40\* or CA41\* HRG costs.

355. The aftercare currencies are:

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

356. The unit cost is per episode of aftercare.

### Neonatal screening

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

### Other audiology services

358. As well as hearing tests, a range of other rehabilitative services are provided through audiology departments, e.g. auditory processing disorders, communication groups, environmental aids sessions, lip reading, relaxation classes, vestibular rehabilitation therapy. These costs should be included against the following currencies if they do not fit with any other currency provided in this guidance:

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



359. The following HRGs relating to audiology are captured using codes within the admitted patient care or outpatient CDS, and should be reported in [Section 3](#) or [Section 4](#) and not here:

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

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

## Day care facilities

361. Day care facilities<sup>82</sup> catering for elderly, stroke, mental health (paragraph 268), and other patients are included in reference costs. Facilities catering primarily for learning disability patients are excluded, as are all services for these patients.

362. The unit cost is per patient day.

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

## Health visitors and midwifery

### Health visitors

364. Currencies for health visitors are consistent with the Healthy Child Programme. The currencies, which include an indication of time spent with the parent or baby for each visit, are as follows:

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

82

[http://www.datadictionary.nhs.uk/data\\_dictionary/nhs\\_business\\_definitions/d/day\\_care\\_facility\\_de.asp?show\\_nav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?show_nav=1)

365. An additional currency, split by face-to-face and non-face-to-face, will cover other statutory contacts with the parent or baby. This will include safeguarding and other statutory contacts (child assessment frameworks, child protection meetings, children in need, looked after children, serious case reviews, and supporting families with complex needs). It will also include public health contacts (clinics, children's centres, and early year's settings).
366. We are continuing a separate currency for Family Nurse Partnership (FNP) programmes delivered by family nurses, in recognition of their more resource intensive nature.
367. Trusts should continue to report immunisations separately at full cost (including travel costs), on the same basis as school based children's services (paragraph 383).

### Midwives

368. Community midwifery services have been divided into:
- (a) ante-natal visits
  - (b) home births
  - (c) post-natal visits.

Home births do not have a specific line on the CHS sheet but should be split over the various delivery codes on the sheet.

### Parentcraft

369. Parentcraft classes are multi-disciplinary, may include health visitors, community midwives and other healthcare professionals, and should be reported as group sessions, the unit of activity will be the number of patients attending the groups.

### Intermediate care

370. Intermediate care<sup>83</sup> is a range of integrated services for adults aged 18 and over to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.
371. Intermediate care services are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less. Care is arranged on the basis of an assessment leading to an intermediate care plan for each individual.
372. Services are predominantly provided by health professionals within multi-disciplinary teams. A core intermediate care team is likely to include support workers, nurses, occupational therapists, physiotherapists and social workers, and to be led by a senior clinician.

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83

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@pg/documents/digitalasset/dh\\_103154.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf)

373. Intermediate care has been described as a function rather than a discrete service, linking and filling gaps in the local network to support patients through periods of transition, and incorporating a wide range of different services. The services that might contribute to the intermediate care function include:

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

374. The key client groups for these currencies are older people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospitals or residential or nursing care homes. Intermediate care may also be provided for older people with mental health needs, e.g. dementia. Where the service is provided to patients with conditions covered by the mental health care clusters, the costs and activity should be included in the mental health care clusters in [Section 9](#), otherwise the costs and activity should be reported here.

375. Table 22 describes the currencies for intermediate care.

**Table 22: Intermediate care currencies**

Currency	Setting	Aim	Period	Activity measure
Crisis response services	Community based services provided to service users in their own home or a care home.	Assessment and short term interventions to avoid hospital admission.	Interventions for the majority of service users will last up to 48 hours or two working days. If longer interventions are provided the service should be included under home based intermediate care	Unit cost per service user
Home based services	Community based services provided to service users in their own home or a care home.	Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living.	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions).	Unit cost per care contact
Bed based services	Service is provided within an acute hospital, community hospital, residential care home, nursing	Prevention of unnecessary acute hospital admissions and premature admissions to long	Interventions for the majority of service users will last up to six weeks (though there will be	Unit cost per occupied bed day

Currency	Setting	Aim	Period	Activity measure
	home, standalone intermediate care facility, independent sector facility, local authority facility or other bed based-setting.	term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital.	Individual exceptions).	

376. These currencies include:

- (a) all admission avoidance schemes wherever their location, which should be included in crisis response (for example teams based in A&E department to identify patients for whom an admission could be avoided)
- (b) early supported discharge in the home, which should be included in home based services, with the exception of condition specific schemes which are excluded as per paragraph 377(e) below.

377. These currencies exclude:

- (a) NHS continuing healthcare and NHS-funded nursing care, eligibility for which might be considered after a patient has finished a period of intermediate care. Costs and activity should be excluded from reference costs against the “NHS continuing care, NHS funded nursing care, and excluded intermediate care” category in [Section 13](#)
- (b) re-ablement services, which are community based services designed to help people recover the skills and confidence to live at home, and are predominately provided by social care professionals within MDTs. Costs and activity should be excluded as set out in (a) above.
- (c) intermediate care delivered to children aged under 18. Costs and activity should be excluded as set out in (a) above
- (d) early supported discharge in the hospital, for example nurses working with ward staff to identify patients who could be discharged to intermediate care. Costs should be included against the appropriate admitted patient care HRGs
- (e) single condition rehabilitation (e.g. stroke). Costs and activity should be reported against the unbundled rehabilitation HRGs in paragraph 223 where care takes place under a specialist rehabilitation consultant or within a discrete unit. Non Specialist stroke and neuro rehabilitation services should be recorded under the relevant community rehabilitation category.
- (f) mental health crisis resolution services, rehabilitation or intermediate care. Costs and activity should be included against the appropriate mental health currencies set out in [Section 9](#)
- (g) general community hospital beds not designated as intermediate care. Costs and activity should be reported as specified in paragraph 233
- (h) general district or specialist nursing services, including community matrons or active case management teams. Costs and activity should be included against the currencies in paragraph 381.

378. We are not introducing case mix adjusted currencies because of the very wide range of underlying medical conditions present within the intermediate care service users.

379. Intermediate care services are typically jointly commissioned and funded by the

clinical commissioning group and local authority. Pooled or unified budgets are sometimes excluded from reference costs ([Section 13](#)), but trusts are encouraged to identify and include activity and costs for all the discrete healthcare elements of the intermediate care service that are provided by the NHS.

## Medical and dental services

### Community dental

Community dental services generally covers dental care provided in community settings for patients who have difficulty getting treatment in their "high street" dental practice and who require treatment on a referral basis, which is not available in a general dental care setting. The currencies for community dental services are as follows:

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

In each case the unit is per care contact – regardless of the units of dental activity (UDA's) which may be counted within that contact.

### Community paediatric

380. Community paediatric services should be reported in [Section 4](#) under TFC 290 and not here.

## Nursing

### Specialist nursing services

381. Specialist nursing services are disaggregated by the bands in Table 23, split further by adult or child and face to face or non-face to face.

**Table 23: Specialist nursing service bands**

National code	Description	Comment
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National code	Description	Comment
N06	Active Case Management (Community Matrons)	
N07	Arthritis Nursing/Liaison	
N08	Asthma and Respiratory Nursing/Liaison	
N09	Breast Care Nursing/Liaison	
N10	Cancer Related	
N11	Cardiac Nursing/Liaison	
N12	Children's Services	See paragraph 383
N14	Continence Services	Exclude costs relating to patients in regular receipt of supplies (e.g. continence pads, stoma bags) which should be reported against home delivery of drugs and supplies (paragraph 451) in <a href="#">Section 13</a>
N15	Diabetic Nursing/Liaison	
N16	Enteral Feeding Nursing Services	
N17	Haemophilia Nursing Services	
N18	HIV/AIDS Nursing Services	Includes follow up of HIV care, psychosocial support, treatment support for individuals starting or switching therapy etc.
N19	Infectious Diseases	
N20	Intensive Care Nursing	
N21	Palliative/Respite Care	
N22	Parkinson's and Alzheimers Nursing/Liaison	
N24	Stoma Care Services	See comment under Continence Services
N25	Tissue Viability Nursing/Liaison	
N26	Transplantation Patients Nursing Service	Includes patients on pre and post transplantation programmes
N27	Treatment Room Nursing Services	To be used for nursing staff based in GP surgeries
N28	Tuberculosis Specialist Nursing	
N29	Other Specialist Nursing	e.g. sickle cell

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

### Nursing services for children

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

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

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

385. The following should be noted for child protection services, where separate to services performed by community paediatricians (paragraph 108):

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

### District nursing services

386. Trusts should make every effort to map district nursing services to the specialist nursing bands. Only if this is not possible should trusts report against district nursing, split by face to face and non-face to face.

### School based children's health services

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

- (a) Core services, including school entry review and year 6 obesity monitoring, further sub-divided into
  - (i) one to one
  - (ii) group single professional
  - (iii) group multi professional (using the same definition of multi professional in paragraph 113).
- (b) Other services, including routine medical checks, sexual and reproductive health advice, family planning, smoking cessation, substance misuse advice and support, obesity and behaviour management (sleep, diet, healthy lifestyles, relationships etc.), further sub-divided into;
  - (i) one to one,
  - (ii) group single professional, or
  - (iii) group multi professional.
- (c) Vaccination programmes – the unit cost is per vaccination. Two vaccinations from a course of three given in the year counts as two, which allows for uncompleted courses.
- (d) Special Schools Nursing. This is a new category for 2014-15 and the unit of activity will be a patient contact.

388. The activities suggested for each category above are not exhaustive, may not all be undertaken by providers and may be known by a different name.



## Wheelchair services

389. In 2013-14 we introduced needs based currencies for non-complex wheelchair services covering assessment, equipment, review and repair and maintenance (Table 24), based on a report commissioned by the Department from Deloitte to develop an initial non-mandatory tariff for these services. These currencies do not cover specialised complex wheelchair services commissioned by NHS England, which should be separately reported on the basis of unit cost per registered user.

**Table 24: Wheelchair service currencies**

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

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

### Assessment currencies

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

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

392. The allocation of costs against these currencies includes provision for prescription of equipment. However, clinical and rehabilitation engineering time associated with

delivery and handover of a wheelchair is included in the equipment currencies detailed below due to the potential for different service providers to complete these tasks.

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

### Equipment currencies

394. The equipment currencies are based on the delivery of a complete “equipment package” of the wheelchair, together with necessary cushions, seating systems, belts or harnesses, modifications and accessories. Users deemed to have a higher level of need on any element of the equipment package would be reimbursed at that higher level of provision for the equipment package as a whole, e.g. a basic chair with an enhanced pressure-relieving cushion would be costed at the medium level of complexity.

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

- (a) low,
- (b) medium,
- (c) high (manual), or
- (d) high (power).

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

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

- (a) chair,
- (b) cushioning,
- (c) accessories,
- (d) occupational therapy technician or rehabilitation engineering time to perform modifications to the chair and fitting of accessories, or
- (e) clinical time associated with checking of modifications and handover of equipment.

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

399. In 2014-15 we are introducing an additional category for specialist modifications without supply. The equipment currencies above are based on delivery of a complete package of chair plus modifications; however there are a number of specialist suppliers who are performing modifications to chairs which have been supplied by another trust. These specialist modifications (without supply of the chair) should be included in this category. The unit of activity should be the number of chairs modified (regardless of the number of modifications included).

### Repair and maintenance currencies

400. The relative complexity of manual and power chairs, different cost base for parts and

the need for annual service or planned preventative maintenance, result in the need for different currencies for each type of equipment. Allocation of costs to these currencies should be made on the following basis:

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

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

## Single condition community rehabilitation teams

402. This section of the collection is for single condition community rehabilitation teams (such as stroke rehab or neuro rehab teams), that are excluded from the intermediate care collection under paragraph 377(e) above, but do not meet the definitions for unbundled rehabilitation HRGs in paragraph 223.

403. Community rehabilitation teams usually include a number of health care professionals providing ongoing care to patients in a community setting. The range of services provided 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, the location of the team has no relevance; although care should be taken not to double count any activity reported using the unbundled rehabilitation HRGs.

404. The activity measure is the number of team contacts in a financial year, e.g. one patient seen by a nurse for three days, twice by a physiotherapist, and twice by a speech and language therapist represents seven team contacts. 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. Where members of a clinical team also see patients in another capacity, (e.g. as a speech and language therapist,) costs and activity should not be reported as part of the community rehabilitation team activity but elsewhere in the collection using the relevant currency, e.g. community speech and language therapy.

405. The collection for community rehabilitation teams will be categorised as follows:

- (a) Stroke Community Rehabilitation Teams,
- (b) Neuro Community Rehabilitation Teams, or
- (c) Other Single Condition Community Rehabilitation Teams.

# Section 11: Ambulance services

## Introduction

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

## Currencies

407. The currencies were developed and agreed with ambulance trusts and commissioners to support the contracting and payment of emergency and urgent ambulance services from April 2012. We plan to align their definitions with the Ambulance Quality Indicators<sup>84</sup>. The four currencies are:

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

## Calls

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

409. Include 999 calls, calls from other healthcare professionals requesting urgent transport for patients, calls transferred or referred from other services (such as other emergency services, 111, NHS Direct, other third parties). Amend 111 calls are excluded from reference costs.

410. Include hoax calls, duplicate or multiple calls about the same incident, hang-ups before coding complete, caller not with patient and unable to give details, caller refusing to give details, response cancelled before coding complete.

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

412. The unit cost is the cost per call.

## Hear and treat or refer

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

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

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<sup>84</sup> <http://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/>

healthcare provider.

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

416. The unit cost is the cost per patient.

### See and treat or refer

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

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

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

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

421. The unit cost is the cost per incident.

### See and treat and convey

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

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

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

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

426. The unit cost is the cost per incident.

## Section 12: Cystic fibrosis

### Introduction

427. This section covers the cystic fibrosis year of care currency that adult and paediatric cystic fibrosis centres<sup>85</sup>, and other providers where network care arrangements are in place, should use to report reference costs.
428. There are two models for the delivery of care for children with Cystic Fibrosis
- Full care which is delivered entirely by a *Specialist* Cystic Fibrosis Centre.
  - Shared care which is delivered by a *Network* Cystic Fibrosis Clinic, which is part of an agreed designated network with a *Specialist* Cystic Fibrosis Centre. The *Network* Cystic Fibrosis Clinic is linked to and led by a *Specialist* Cystic Fibrosis Centre.
429. For the purposes of the reference costs collection, for children, there are two worksheets in the collection workbook, one to capture costs and activity from trusts delivering 100% care in their capacity as a *Specialist* provider and one to capture costs and activity from trusts delivering care in their capacity as a *Network* provider. Individual trusts may provide care under both arrangements.
430. The complexity of Cystic Fibrosis in adults means
- Full care delivered by a multidisciplinary team from a *Specialist* Cystic Fibrosis Centre is the only model of delivery of care recognised for adults with Cystic Fibrosis.
  - For patients' convenience, care may be delivered through an *Outreach* Clinic as part of an agreed designated network.
431. For the purposes of the reference costs collection, for adults, there are two worksheets in the collection workbook, one to capture costs and activity from trusts delivering 100% of care in their capacity as a *Specialist* provider and one to capture costs and activity from trusts delivering care in their capacity as an *Outreach* provider. For the purposes of the collection, *Outreach* cost and activity should be recorded on the *Network* care spread sheet. Individual trusts may provide care under both arrangements.
432. The Grouper generates HRGs for cystic fibrosis (DZ13\*, PA13\*) that we will remove from the reference costs workbook – their costs should be included in the year of care currencies.
433. To support quality improvements in these year of care costs, we recommend that trusts should:
- calculate costs against the 2014 calendar year bands issued in February 2015 by the Cystic Fibrosis Trust, with no further local adjustment,
  - ensure the data from network care providers conforms with this banding data before submission,

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<sup>85</sup> <https://www.cysticfibrosis.org.uk/about-cf/cystic-fibrosis-care/uk-specialist-cf-centres.aspx>

- (c) ensure that all patients are allocated to the appropriate specialist and network care reporting lines, and
- (d) separate new patients from normal band 2a patients using the reporting lines provided.

## Year of care currencies

434. Under the year of care currency model, each patient is allocated to one of seven bands derived from clinical information including cystic fibrosis complications and drug requirements, each of which describes an increasingly complex year of care. The bands are described in the SSNDS Definition No. 10 Cystic Fibrosis Services (all ages) (3rd Edition)<sup>86</sup>.
435. The Cystic Fibrosis Trust<sup>87</sup> produces the bandings based on data returned by both specialist centres and network care providers to its national database, the UK Cystic Fibrosis Registry. Trusts should access their banding data from the Registry through their lead clinician.
436. Allocations to bands are based on data from the calendar year before the next financial year and are issued each February. The 2014 calendar year bands issued in February 2015 by the Cystic Fibrosis Trust should be used for 2014-15 reference costs.
437. Because cystic fibrosis is a long term condition there is relatively little movement between bands from one year to another, rather there is a steady progression of disease severity over several years. There will be no movement of patients between bands during any one financial year.
438. The currencies themselves make no distinction between adults and children. However, in order to understand the cost differentials we have retained a split in reference costs between adults (defined here as patients aged 17 and over) and children (defined as patients aged 16 and under).

## Part year of care

439. There are likely to be increases and decreases in the numbers of patients in each band in any one centre during the financial year. This will be due to births, newly diagnosed patients, transition from children's to adult services, natural patient movement from one location to another, transplantation and deaths. Because costing will be done on the basis of bands issued in February, we expect that this will have minimal impact. However, to ensure the bands only show full year of care costs, and to maintain the principle of full absorption costing, we have provided separate reporting lines for part year of care patients.
440. Newly diagnosed patients and new births will be banded as 2A, which recognises the additional costs associated with diagnosis and treatment of a new patient. These patients will be revised by the Cystic Fibrosis Trust when the bandings are reissued for the following year.

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<sup>86</sup> <http://www.specialisedservices.nhs.uk/doc/cystic-fibrosis-services-all-ages>

<sup>87</sup> <http://www.cftrust.org.uk/>



441. Clinical transition from a children's to an adult service or transfer to another centre may take place over a period of time. For the purposes of payment the two centres must agree a date at which responsibility for care will transfer, and this will inform the reporting of part year costs.
442. In some cases, such as where young people are away at university or patients need care whilst on holiday, there may not be a formal transfer of care as an individual may not wish or need to have their care transferred to a new centre. Should treatment be required away from the centre responsible for their care, the responsible centre will be expected to cost this under a provider-to-provider agreement (paragraph 485).

## Network and Outreach care

443. Network care is a recognised model for paediatric care, where children may not receive all their care at a specialist centre and may receive some care at other local hospitals or clinics under network care arrangements. Likewise, for patient convenience, care may be delivered to adult patients at an Outreach clinic, designated as part of a network agreement.
444. Specialist centres who provide 100% of the year of care for patients in a given band should return costs and activity under service code "SPEC" on the "CF" fixed worksheet.
445. Specialist centres, network care providers and outreach clinic providers who provide less than 100% of the year of care for patients in a given band, because a proportion of the care is undertaken by another provider under a network arrangement, should additionally complete the "Cystic Fibrosis – network care arrangements in place worksheet" (as illustrated in Table 25) by:

Recording their own trust's part year of care costs and activity under service code "NET" on the "CFNET" flexible worksheet, broken down by:

- a) bands, and by the
- b) organisation code of the corresponding care provider. A list of organisation codes can be found at the end of the collection workbook in the "Reference" tab. (The Reference Costs Team will be able to match network providers recorded, to generate a full year of cost per patient treated under a shared care arrangement).

**Table 25: Reporting part year of care costs for cystic fibrosis under network care arrangements**

Service Name	Currency Name	Dept. Code	Service Code	Currency Code	Part year of care cost per patient	No. of patients	Org code of other specialist or network care provider
Network Care	Cystic fibrosis band 1 children 16 years and under	CF	NET	B1C	2,000.00	20	R1A
Network Care	Cystic fibrosis band 1 children 16 years and under	CF	NET	B1C	1,500.00	10	R1C
Network Care	Cystic fibrosis band 1 children 16 years and under	CF	NET	B1C	2,000.00	5	R1D
Network Care	Cystic fibrosis band 1A children 16 years and under	CF	NET	B1AC	2,500.00	10	R1A
Network Care	Cystic fibrosis band 1A children 16 years and under	CF	NET	B1AC	3,000.00	5	R1C
Network Care	Cystic fibrosis band 2 children 16 years and under	CF	NET	B2C	4,000.00	2	R1A

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

## Costing cystic fibrosis

447. The costs submitted against the bands issued in February 2015 should cover all cystic fibrosis related care for the 2014-15 financial year. This includes:

- (a) Any admitted patient care episode or outpatient attendance that is for the purpose of cystic fibrosis, regardless of whether it is one of the DZ13\* or PD13\* HRGs or not, whether delivered at a specialist centre or network care provider. Examples include patients admitted for treatment of exacerbation of chest infection, admitted for medical treatment of cystic fibrosis distal intestinal obstruction syndrome, or admitted with a new diagnosis of cystic fibrosis related diabetes to establish a new insulin regimen. To help identify activity, TFCs for adult cystic fibrosis (TFC 343) and paediatric cystic fibrosis (TFC 264) should be used as described in the Data Dictionary<sup>88</sup>. A primary diagnosis of cystic fibrosis may also be a useful way to identify cystic fibrosis specific care.
- (b) Home care support, including home intravenous antibiotics supervised by the cystic fibrosis service, home visits by the multidisciplinary team to monitor a patient's condition (e.g. management of totally implantable venous access devices (TIVADs)), collection of mid-course aminoglycoside blood levels, and general support for patient and carers.
- (c) Intravenous antibiotics provided during admitted patient care.
- (d) Annual review investigations.

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

- (a) The high cost, cystic fibrosis specific, inhaled or nebulised drugs Aztreonam lysine, Colistimethate sodium, Dornase alfa, Mannitol and Tobramycin as well as Ivacaftor in any form. The total cost of these drugs for all full year of care and part year of care patients should be reported in the excluded services worksheet (paragraph 451). The cost of each of these drugs in each band for full year of care patients, but excluding part year of care patients, should also be separately noted in the outpatient (regardless of setting) columns of the drugs and devices worksheet (paragraph 497).

- (b) Unrelated care which will be assigned to the relevant HRG or TFC, e.g. obstetric care for a pregnant woman with cystic fibrosis, ENT outpatient review for nasal polyps. Cystic fibrosis ICD-10 codes are included in HRG complication and comorbidity lists and recognised in HRG4+ output.
- (c) Insertion of gastrostomy devices and insertion of TIVADs are not included in the annual banded tariff. The associated surgical costs should be covered by the relevant separate codes.
- (d) Costs associated with long-term nutritional supplementation via gastrostomy or nasogastric tube feeding, which remain within primary medical services.
- (e) Costs associated with all other chronic non cystic fibrosis specific medication prescribed by GPs and funded from primary medical services, e.g., long-term oral antibiotics, pancreatic enzyme replacement therapy, salt tablets, and vitamin supplements.
- (f) Costs associated with high cost antifungal drugs that generate an unbundled high cost drug HRG.
- (g) Neonates admitted with meconium ileus should be costed against the relevant HRG. Annual banding should not include the period they spent as an admitted patient receiving their initial surgical management.
- (h) Patient transport services.

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

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

## Section 13: Services excluded from reference costs

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

452. The services listed in Table 26 are excluded from reference costs because they meet one or more of the following criteria:

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

453. Only these services may be excluded. Their total cost should be excluded using full absorption costing, and recorded on the reconciliation statement.

**Table 26: Services excluded from reference costs**

Excluded service	Definition or description	Why is the service excluded?
Ambulance trusts – specified services	<p>The following services or costs are excluded (ambulance trusts only):</p> <ul style="list-style-type: none"> <li>• Air ambulance service</li> <li>• Chemical biological radiological and nuclear costs</li> <li>• Decontamination units</li> <li>• Emergency bed service</li> <li>• Emergency planning</li> <li>• Hazardous area response teams</li> <li>• Helicopter emergency medical services (part provided by Barts Health NHS Trust)</li> <li>• Logistics or courier transport service e.g. collecting clinical waste</li> <li>• Neonatal transfers (non-ambulance trusts should report the costs of neonatal critical care transportation under HRG XA06Z)</li> <li>• Out of hours services</li> <li>• Patient education</li> <li>• Single point of access telephony services (e.g. 111, NHS direct)</li> </ul> <p>No other service, and no other provider type to ambulance trusts, may be excluded in this category without our permission.</p>	These services are not part of the ambulance service currencies for contracting, and no other suitable currency exists
Cystic fibrosis drugs	<p>The high cost, cystic fibrosis specific, inhaled or nebulised drugs Aztreonam lysine, Colistimethate sodium, Dornase alfa, Mannitol and Tobramycin are excluded as is Ivacaftor in any form. The cost of these drugs should also be separately reported by cystic fibrosis banding in the drugs and devices worksheet (paragraph 448).</p>	These drug costs are not part of the mandatory cystic fibrosis year of care currency.

Excluded service	Definition or description	Why is the service excluded?
Discrete external aids and appliances	This exclusion is intended for discrete services such as artificial limbs or eyes, and covers both the costs of the services and of the appliances. It is not intended for aids such as synthetic wigs, custom footwear or orthoses that are an integral part of the care plan for services such as podiatry (paragraph 340), and that are provided during an admitted patient episode or outpatient attendance.	No suitable currencies exist.
Health promotion programmes	Health promotion programmes are delivered to groups rather than individuals and are directed towards particular functions (such as parenthood), conditions (such as obesity), and aspects of behaviour (such as drug misuse).  The exclusion is further broken down into the following classifications, and total costs should be provided for each: <ul style="list-style-type: none"> <li>• Contraception and sexual health</li> <li>• Oral health promotion</li> <li>• Stop smoking education programme</li> <li>• Substance misuse</li> <li>• Weight management</li> <li>• Other health promotion programme.</li> </ul>	We are considering suitable activity measures with a view to collecting unit costs in 2015-16 reference costs.
Home delivery of drugs and supplies: administration and associated costs	Trusts incur costs in delivering drugs, oxygen, blood products or supplies directly to patient's homes, without any associated clinical activity at the time of delivery.  On this line, trusts should include the administration and associated costs relating to home delivery of drugs and supplies, including: <ul style="list-style-type: none"> <li>• costs of enrolling patients and the managing of the home care service</li> <li>• costs of contracting, ordering, invoice matching and payment</li> <li>• nurse support of a non-clinical nature</li> <li>• any other associated administrative costs.</li> </ul>	There is currently no national requirement to understand the unit costs of providing this service.
Home delivery of drugs and supplies: drugs, supplies and associated costs	On this line, trusts should include the costs of the: <ul style="list-style-type: none"> <li>• drugs, including oxygen or blood products</li> <li>• supplies, e.g. continence pads or enteral feeding</li> <li>• delivery of drugs or supplies</li> <li>• any other associated drug or supply costs.</li> </ul>	There is currently no national requirement to understand the unit costs of providing this service.
Hospital travel costs scheme	Scheme offering financial help with the cost of travel to and from hospitals and other NHS centres <sup>89</sup> .  Note that overnight stays are not part of the HTCS.  However, the HTCS guidance states: " Where an overnight stay away from home is unavoidable, either because of the time of the appointment or length of travel required, and the patient is unable to meet the cost of this stay, the expense should be treated as part of treatment costs or met through non-Exchequer funds. This should be discussed with the relevant CCG before the overnight stay occurs."  Providers should therefore include overnight stays as an overhead in their reference costs.	Because this scheme makes fixed payments to eligible NHS patients there is no requirement to understand or benchmark provider unit costs.

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

Excluded service	Definition or description	Why is the service excluded?
Learning disability services		We will consider whether to include learning disability services in reference costs from 2015-16
Local Improvement Finance Trust (LIFT) and Private Finance Initiative (PFI) set up costs	See paragraph 455	These are one-off costs.
Mental health trusts – specified services	The following services delivered by mental health trusts: <ul style="list-style-type: none"> <li>• Acquired brain injury</li> <li>• Neuropsychiatry</li> </ul> No other service, and no other provider type to mental health trusts, may be excluded in this category without our permission.	No suitable currencies exist.
Named providers – specified services	The following services are excluded: <ul style="list-style-type: none"> <li>• Clinical Toxicology Service - Guy's and St Thomas' NHS Foundation Trust</li> <li>• Fixated threat assessment centre - Barnet, Enfield and Haringey Mental Health NHS Trust</li> <li>• High secure infectious disease units - Royal Free London NHS Foundation Trust and The Newcastle upon Tyne Hospitals NHS Foundation Trust</li> <li>• Low energy proton therapy for ocular oncology - Clatterbridge Centre for Oncology NHS Foundation Trust</li> <li>• National Poisons Information Service - The Newcastle Upon Tyne Hospitals NHS Foundation Trust</li> <li>• National Artificial Eye Service – Blackpool Teaching Hospitals NHS Foundation Trust</li> </ul> No other service provided by any other provider may be excluded in this category without our permission.	These are unusual services, each provided by one or two named providers, where there is currently no requirement to submit costs for benchmarking or any other purpose.
NHS continuing healthcare, NHS-funded nursing care and excluded intermediate care for individuals aged 18 or over	NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a “primary health need” as set out in guidance <sup>90</sup> . Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. It can be provided in any setting including, but not limited to a care home, a hospice or a patient's home.  NHS-funded nursing care is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse.  Excluded intermediate care is those services defined in paragraph 377	We wish to first test the collection of intermediate care services in <a href="#">Section 10</a> before considering NHS continuing healthcare.

<sup>90</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf)



Excluded service	Definition or description	Why is the service excluded?
NHS continuing healthcare, NHS-funded nursing care for children.	<p>NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a “primary health need” as set out in guidance<sup>91</sup>. Such care is provided to an child, to meet needs that have arisen as a result of disability, accident or illness. It can be provided in any setting including, but not limited to a residential care home, hospice or the patient’s own home.</p> <p>NHS-funded nursing care is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse.</p>	Lack of robust activity data.
Patient transport services (PTS)	Services run by ambulance trusts and other PTS providers offering free transport to and from hospital for people who have a medical need.	Patient transport services were included in reference costs between 2006-07 and 2009-10 and excluded from 2010-11. We will consider whether they could again be included from 2015-16.
Pooled or unified budgets	<p>As a general principle, costs and activity are excluded for services jointly provided under pooled or unified budget arrangements with agencies outside the NHS such as social services, housing, employment, education (e.g. Sure Start), home equipment loans or community equipment stores</p> <p>This also includes:</p> <ul style="list-style-type: none"> <li>costs relating to advice to non-NHS bodies (e.g. paragraph 385(c))</li> <li>vaccination programmes part-funded by GPs or non-NHS providers</li> </ul> <p>Where trusts are confident that they can</p> <ul style="list-style-type: none"> <li>separately identify a discrete element of the service that is funded by the NHS and</li> <li>identify the total costs incurred by that service</li> <li>have accurate and reflective activity data</li> </ul> <p>then they are encouraged to include that service.</p>	<p>Services provided by bodies outside the NHS such as local government are outside the scope of reference costs.</p> <p>We are aware that this is likely to become a bigger issue in future years as engagement with other agencies increases. With this in mind we will be discussing it at the community RCAG and will convene a working group to consider treatment of pooled or unified budgets for future collections.</p>
Primary medical services	Services provided under a primary medical services contract (General Medical Services (GMS), Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) and Specialist Medical Provider Services (SPMS)). Includes GP provided open access services and GP out of hour’s services.	Primary medical services are subject to separate funding arrangement and are outside the scope of reference costs.
Prison health services		Availability of activity data has been an issue with prison health services. However, some costs and activity, are included in reference costs (prison health and mental health specialist teams, paragraph 320(h)), and we will consider whether other costs and activity should be included in 2015-16

<sup>91</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf)



Excluded service	Definition or description	Why is the service excluded?
Screening programmes	National screening programmes <sup>92</sup>	Treatment varies – some national screening programmes are excluded and some are included. See Table 27
Specified hosted services	<p>Services hosted in one provider, providing benefit for the patients of other providers. The specified services are:</p> <ul style="list-style-type: none"> <li>Genetic laboratory services - specialist laboratory services that are nationally commissioned and members of the United Kingdom Genetic Testing Network (UKGTN)<sup>93</sup>. Each laboratory carries out rare genetic tests for a large number of hospitals</li> <li>Intensive care support services - services providing transport, advice or other services for critical care patients on a regional basis.</li> </ul> <p>No other service may be excluded in this category without our permission.</p>	There is no patient event to which costs can be allocated. The host provider is fully funded, and there is no recharge to other provider.

454. The inclusion or exclusion of national screening programmes varies. Table 27 clarifies the treatment of each programme.

**Table 27: UK national screening committee programmes**

Programme	Included or excluded
<b>Antenatal and newborn</b>	
NHS Fetal Anomaly Screening Programme	Included in relevant maternity outpatient and admitted patient costs
NHS Infectious Diseases in Pregnancy Screening Programme	Included in relevant maternity outpatient and admitted patient costs
NHS Linked Antenatal and Newborn Sickle Cell and Thalassaemia Screening Programme	Included in relevant maternity outpatient and admitted patient costs. Exception is for the small number of genetic tests that occur, which are excluded and should be funded directly by PCTs
NHS Newborn and Infant Physical Examination Screening Programme	Included in the cost of maternity delivery HRGs or postnatal visits
NHS Newborn Blood Spot Screening Programme	The taking of the sample is included in the cost of maternity delivery HRGs or postnatal visits. Its analysis by regional newborn screening services is excluded from reference costs
NHS Newborn Hearing Screening Programme	Included in audiology services neonatal screening (paragraph 357)
<b>Young person and adult</b>	
NHS Abdominal Aortic Aneurysm Screening Programme	Excluded
National Screening Programme for Diabetic Retinopathy	Included in diabetic retinal screening, which should be reported as a directly accessed diagnostic service against HRG WA20Z
NHS Breast Screening Programme	Excluded
NHS Cervical Screening Programme	Excluded
NHS Bowel Cancer Screening Programme	Excluded
<b>Related programmes<sup>94</sup></b>	
Health check (vascular risk)	Excluded
Chlamydia screening	Excluded
Prostate cancer	Excluded

<sup>92</sup> <http://www.screening.nhs.uk/index.php>

<sup>93</sup> <http://www.ukgtn.nhs.uk/gtn/Home>

<sup>94</sup> Not approved by the UK national screening committee

455. Table 28 clarifies the treatment of PFI or LIFT expenditure. As a general principle, PFI or LIFT set up costs include one off revenue costs incurred in setting up a PFI or LIFT scheme from the initial business case stage to financial close. This includes fees (consultancy, legal, financial etc.) and other costs such as planning applications. These set up costs should be excluded from reference costs.

**Table 28: PFI and LIFT expenditure**

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

# Section 14: Reconciliation

## Introduction

456. This section covers the following worksheets in the reference costs return:

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

457. It is desirable to complete the reconciliation at the start of the reference costing process. Identifying the excluded services in [Section 13](#), costs (or income) relating to non-patient care activities, and agreeing totals to final accounts will provide confidence that the correct reference cost quantum has been established before costing services.

458. Although each trust will have their own process, the following steps may apply:

- (a) ensure the financial accounts are closed and the final version of the general ledger is available
- (b) obtain the final trial balance or drawdown the general ledger, or both, and ensure they agree, at detailed account code level
- (c) allocate the lines on the trial balance/download to the lines on the reconciliation worksheet. At this stage, it may be possible to extract data for the drugs and devices worksheet, and for allowable income
- (d) check the figures obtained in the step above agree to the final audited accounts spreadsheets (TRUs for NHS trusts, FTCs for NHS foundation trusts). It may be necessary to ask colleagues in financial accounts for this information
- (e) complete the reconciliation worksheet to the total costs in **Line 28** and ensure this agrees to the trial balance/download
- (f) check the data against last years to identify any material or unexpected variations, and investigate if needed
- (g) import this quantum into the costing system
- (h) identify the costs of non-NHS patients and excluded services from the outputs of the costing system and add these to the appropriate lines in the reconciliation statement

- (i) ensure the total reference cost quantum in the completed reference costs workbook agrees to the total reference cost submission quantum in **Line 28** on the reconciliation worksheet
- (j) complete the drugs and devices worksheet
- (k) final check of the reconciliation statement against last years to identify any material or unexpected variations, and investigate if needed.

## Non-patient care activities

459. Education and training, research and development, and commercial or other activities not primarily related to providing care to NHS patients are funded from sources other than contracts with NHS commissioners, are not reimbursed through national prices, and therefore should be excluded from reference costs.
460. To date, our approach has been to require trusts to net off income associated with these funding streams from their operating expenses before calculating reference costs. This assumes that income exactly matches the costs. However, if income is more than costs, this has the impact of lowering reference costs below the real cost of providing patient care. Similarly, if income is less than costs, this has the impact of raising reference costs above the real cost of providing patient care.
461. We are therefore working towards a position in future years where the cost of providing the service, rather than the income from the service, is excluded from reference costs. Trusts should refer to Standard 7 of the *HFMA Clinical Costing Standards* for guidelines on separating the costs of non-patient care activities from the costs of providing patient care.
462. Progress on costing education and training is set out in paragraph 9.
463. All remaining income received from commercial or other non-patient care activities should continue to be netted off in 2014-15. The allowable income should be matched to the service where the income was generated, offsetting the cost of providing the service.

## Reconciliation worksheet

464. There is a single reconciliation worksheet for both NHS trusts and NHS foundation trusts, to be completed in £ not in £ thousands.
465. This worksheet reconciles the data recorded in the audited financial statements to the total reference cost quantum. References to lines in the TRUs/FTCs are included where applicable.
466. Trusts obtaining foundation trust status part way through a financial year must include the total of their TRUs and FTCs in order to balance back to their total reference cost quantum. **Line 20 Other gains and losses** has been added to the FTC statement so part year foundation trusts do not need to recalculate the TRU figures to fit the FTC layout. Where there are other presentational differences, e.g.

finance costs unwinding of discount, there is no need to restate the TRUs to fit the FTC description, but all costs must be included.

467. The worksheet starts with the total operating expenses reported in the financial statements. There are then a number of adjustments to remove expenditure that is not included in the calculation of reference costs, or to deduct income that should be netted off. Trusts must ensure there is no double counting or double netting off.
468. Net gain or loss on transfer by absorption is not included when calculating reference costs and therefore has no line on the worksheets.
469. **Line 1 Operating expenses** is the starting point to ensure all costs are included in quantum.
470. Where a trust produces a consolidated set of accounts, the expense figure shown here should be the total operating expenses of the consolidation. The operating expenses of entities with which the trust consolidates should be deducted on lines 14 to 18 with a description of the adjustment.
471. **Line 2 Less cost of non-NHS private patients** – deduct the costs of providing care to private patients
472. **Line 3 Less cost of non-NHS overseas patients (non-reciprocal)** – deduct the costs of providing care to overseas visitors to the UK who are not exempt from charge under the NHS (Charges to Overseas Visitors) Regulations 2011. This includes most irregular migrants, visitors from a country that the UK does not have a reciprocal agreement with, and some UK citizens residing overseas. Do not deduct the costs of overseas patients (reciprocal)<sup>95</sup>. Their care is commissioned via the CCG and should be included in reference costs as though they were registered or resident in England.
473. **Line 4 Less cost of other non-NHS patients** – deduct the costs of providing care to the following non-NHS patients, including:
- (a) Armed forces personnel - funded by the Ministry of Defence (MoD) where the requirement varies from the standard NHS pathways in either the treatment requested or management requirements (e.g. fast-track care or non-standard treatment), and identified by the code XMD rather than the CCG code for data submission purposes. Non-standard care arrangements are normally the subject of specific MoD contracts or by prior agreement with the MoD referrer<sup>96</sup>.
  - (b) Patients from the devolved administrations (Scotland, Wales and Northern Ireland) - parliament votes the NHS budget based on the requirements of NHS patients in England i.e. those resident in England and legally entitled to NHS care.
474. **Line 5 Less other operating income** – deduct income for the following funding streams, the sum of which must equal other operating income in the relevant line of the financial statements for NHS trusts (TRU01) or NHS foundation trusts (6. Op Inc. (type)):

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

<sup>96</sup> <https://www.gov.uk/government/publications/health-services-for-the-armed-forces-and-veterans>

- (a) **Line 5a non-salaried education and training income**
- (b) **Line 5b salaried education and training income**
- (c) **Line 5c research and development**, which comprises several funding streams. For reference costs, only research and development income relating to costs that end when the research ends should be deducted here. The following funding streams are allowable income:
  - (i) Research - research grant funding, to pay for the costs of the R&D itself (e.g. writing the research paper), received from the Department of Health (including the National Institute for Health Research (NIHR)), other government departments, charities, and the Medical Research Council (MRC) which includes funding for Biomedical Research Centres, Biomedical Research Units and Collaborations for Leadership in Applied Health Research and Care (CLARHC).
  - (ii) NHS support - funding from the Department of Health (NIHR) to cover additional patient care costs associated with the research (e.g. extra blood tests, extra nursing time) that end when the research ends.
  - (iii) Flexibility and sustainability funding - funding from the Department of Health mainly to support NIHR faculty and associated workforce.

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

- (iv) Treatment costs including excess treatment costs – funding from normal commissioning arrangements to cover patient care costs associated with the research that continue to be incurred after the research ends if the service in question were to continue.
- (v) Subventions - exceptional funding from the Department to contribute to the cost of very expensive excess treatment costs.

NHS England are reviewing how excess treatment costs might be funded differently in the future. This could have implications for the future reporting of these costs in reference costs.

- (d) **Line 5d other income from non-patient care activities**. Income from other non-patient care activities, such as commercial income (e.g. car parking, hospital shop leases), or charitable contributions to expenditure, should be netted off operating costs<sup>97</sup>. Where the income relates to services excluded from reference costs, care must be taken to ensure it is not netted off. There are no costs in the submission to which this income can be matched.

**Line 6 Add not allowable income.** Add back Income included in Line 5 that cannot be netted off or is reported elsewhere. Income included in Lines 5 above that cannot be netted off when calculating reference costs (because it relates to patient care activities), must be added back on this line.

<sup>97</sup> Table 66 in the reference costs guidance for 2012-13 at <https://www.gov.uk/government/publications/reference-costs-guidance-for-2012-13> gives further examples of allowable income.



(Examples include winter pressure monies, CQUIN, transitional relief, targeted patient care or injury cost scheme, but only where these costs have been included in Lines 5 above).

Income included in Lines 5 above which is reported separately on other lines of the reconciliation statement ( e.g. Funds received for foundation trust application, centrally funded clinical excellence awards) should be added back here and reported separately on the appropriate lines of the statement to avoid double counting).”

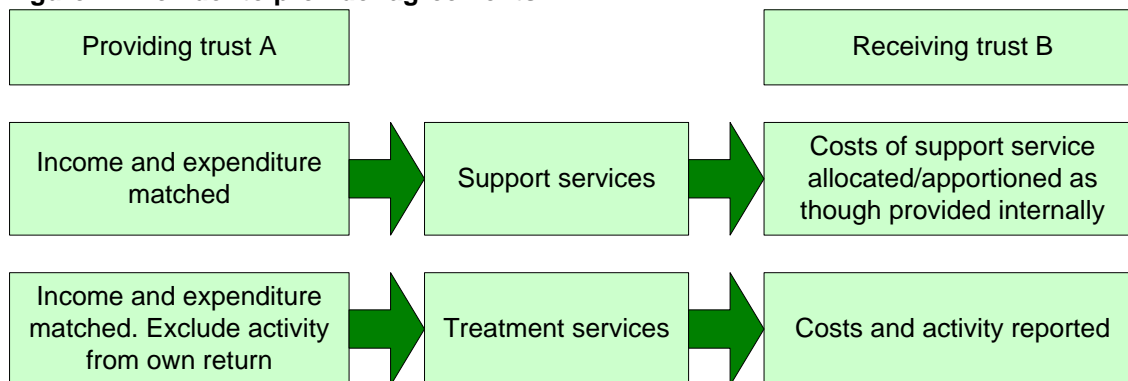
475. **Line 7 Less cost of centrally funded awards under the clinical excellence awards scheme.** Only centrally funded awards under the clinical excellence awards scheme (levels 9 to 12, or distinction award levels B, A and A+ under the previous scheme) should be netted off. Internally funded awards (levels 1 to 9, or discretionary points levels 1 to 8 under the previous scheme) should not be netted off. Where centrally funded and locally funded awards are included in **Line 5d Other operating income** the amount must be added back there in order to be deducted here, to avoid double netting off.
476. **Line 8 Less funds received for foundation trust application.** Where these are included in **Line 5 Other operating income** the amount must be added back there in order to be deducted here.
477. **Line 9 Less PFI or LIFT exclusions.** The set up costs of PFI or LIFT schemes should be recorded on **Line 25o**. Any profit/loss from the sale of non-current assets in a PFI or LIFT deal should also be included here to net off the gain or loss. This would be recorded in income/expenditure for NHS foundation trusts or other gains and losses in NHS trusts.
478. **Line 10 Less impairments.** Impairments charged through the Statement of Comprehensive Income are not included in reference costs and must be removed. These should be split between:
- (a) **Line 10a New build**
  - (b) **Line 10b Other.**
479. **Line 11 Add reversal of impairments.** Conversely, the reversal of an impairment must be added back. These should be split between:
- (a) **Line 11a New build**
  - (b) **Line 11b Other.**
480. **Line 12 Depreciation related to donated/government granted non-current assets and Line 13 Add donations/government grants received to fund non-current assets.** Costs and income associated with donated/government granted non-current assets must be removed. Income received in year is added back (as this will have been deducted in **Line 5**), and any charges to expenditure such as depreciation are deducted (these will be included in **Line 1**). Take care not to remove impairments, which will have already been deducted in **Line 10 Less impairments**. The income may be actual cash donated to purchase an asset or the asset value where an asset has been donated; the treatment here will be the same.
481. Following a change to the interpretation of accounting standards, the treatment of the



credit entry relating to donated assets is no longer held in reserves and used to offset charges to expenditure. The funding element is now recognised as income in year as required by IAS 20 as interpreted by the HM Treasury Financial Reporting Manual.

482. In the year when the asset is received, the trust will have income equal to the value of the asset and a much smaller depreciation charge to expenditure. To prevent any instability in reference costs quantum caused by this large net income in the year of receipt, followed by years of increased costs (i.e. the depreciation charge etc.), all income and expenditure relating to donated assets must be excluded from reference costs.
483. This will bring the treatment in line with previous years where the income released from reserves would be equal to the depreciation etc. charged and so have a nil effect on reference costs. Impairments will not be an issue as these are not included in reference costs. This change relates equally to government granted assets.
484. **Lines 14 to 18** are blank rows that have been left for trusts to add adjustments that have not been included in the reconciliation. Full details of the adjustment must be provided and must have been agreed in advance of the submission with DH via e-mail ([referencecosts@dh.gsi.gov.uk](mailto:referencecosts@dh.gsi.gov.uk)). The entries on these lines will be monitored throughout the collection window; if DH finds entries with no prior agreement or no suitable explanation they may contact the provider in question.
485. **Line 19 Less adjustment for provider-to-provider agreements.** Where there are provider-to-provider agreements for support services (e.g. an administration service, or a service where a trust pays for expenditure on behalf of another trust and is then reimbursed) or treatment services, the costs and associated income should be treated as in Figure 7.

**Figure 7: Provider to provider agreements**



486. The providing trust (A in Figure 7) in these agreements should:

- for support services - record both expenditure and income, which should be matched in line with the costing principles, resulting in a nil net cost. The income from providing the service would be posted to other operating income and so will already have been netted off expenditure in **Line 5d**
- for treatment services – follow the same approach as for support services. Where treatment has been provided to a non-NHS patient, no adjustment will be needed here because the costs will already have been deducted in **Lines 2 to 4**. Where the treatment is provided to an NHS patient in another NHS trust then the costs will need to be deducted on **Line 19**. Any activity should be

excluded from the reference costs workbook.

487. The receiving trust (B) should:

- (a) for support services - include the cost paid to the providing trust in its own reference costs, allocated and apportioned on a consistent basis, as if it had provided the service itself. There should be no need for an adjustment in **Line 19**
- (b) for treatment services – follow the same approach as for support services, recording both the costs and activity in its reference costs return.

488. **Line 20 Add other gains and losses**, for NHS trusts only or foundation trusts obtaining foundation trust status in year, for the part of the year they were an NHS trust. This will be mainly profit/loss on disposal of non-current assets, which is included in expenditure or other income in foundation trust accounts and therefore does not need to be adjusted. Profit/loss on disposal of non-current assets must be included in the reference cost quantum, with the exception of those in a new PFI or LIFT scheme, or those arising through transfer of donations (paragraph 34(c)).

489. **Line 21 Less investment revenue or finance income** is interest received.

490. **Line 22 Add finance costs or finance expenses** is interest payable and other costs associated with financing. In NHS trusts, it will also include unwinding of discount on provisions.

491. **Line 23 Add PDC dividends payable** is the PDC payables figure from the Statement of Comprehensive Income, not the cash flow figure.

492. **Line 24 Add finance expenses - unwinding of discount** applies to NHS foundation trusts only and is the cost of the unwinding of discounts on provisions. In NHS trusts it is included in **Line 25**.

493. **Line 25 Services excluded from reference costs collection** as listed in [Section 13](#).

494. **Line 26 Less total cost of services sub-contracted out to non-NHS bodies**. The total cost to the trust of sub-contracting out services to the independent sector. Include the fully absorbed cost wherever possible. For example, a trust might have an arrangement with their consultants to carry out private work on-site, paid for at a proportion of the tariff price. The cost should include not only the agreed price, but also the overhead costs of the consultants using NHS theatres, consumables etc. in the course of their private work.

495. **Line 27 Add cost of services sub-contracted out to non-NHS bodies included within reference costs**.

496. **Line 28 Total reference cost submission quantum** is the sum of **Lines 1 to 27** and must agree to within +/- 1% of the main reference cost submission.

## Drugs and devices

497. Costs and activity relating to all devices, even if currently excluded from national

prices, must be included against the HRG to which they relate.

498. The high cost drug OPCS codes, and therefore the unbundled high cost drug HRGs (paragraph 208), do not capture all high cost drugs. Others must be included in the costs of the relevant core or unbundled HRG.

499. To inform price setting, and in addition to including the costs against the appropriate currencies, memorandum information about specified drugs and devices must be reported in the drugs and devices worksheet. The data may be used to adjust national prices to reflect the exclusion of some high cost drugs and devices. It is necessary to make these adjustments outside reference costs as the drugs and devices that are unbundled and/or included in national prices may change during the lag between collecting reference costs and setting prices. The National Casemix Office also uses the data when assessing HRG design.

## Survey

500. Table 29 contains details of the mandatory survey to collect information about PLICS implementation and use, levels of clinical and financial engagement, and other information to inform national policy making.

**Table 29: Reference costs survey**

All trusts		
Q1	What is the status of patient level information and costing systems (PLICS) in your organisation?	<ul style="list-style-type: none"> <li>• Implemented<sup>98</sup></li> <li>• Implementing<sup>99</sup></li> <li>• Planning</li> <li>• Not planning</li> </ul>
Q2	How many whole-time equivalent (WTE) staff <sup>100</sup> are engaged in running your costing system and producing cost information:	
Q2a	• Finance staff?	[number of WTEs]
Q2b	• Information staff?	[number of WTEs]
Q2c	• Other staff?	[number of WTEs]
Q3	What is the resource commitment (in number of working days) of collating and submitting the annual reference costs return <sup>101</sup> by the following occupational groups:	
Q3a	• Finance staff?	[insert number of days]
Q3b	• Information staff?	[insert number of days]
Q3c	• Senior managers?	[insert number of days]
Q4	Is your team responsible for returning any other cost collections for your organisation?	

<sup>98</sup> IT system purchased, installed and being used to cost at least some services. Where the trust has a PLICS system, but are in the process of updating or replacing it, they should still consider themselves as having implemented PLICS.

<sup>99</sup> IT system is in the process of being purchased and installed.

<sup>100</sup> Disregard time spent on other activities, e.g. 2 WTEs spending 60% of their time running the system should be reported as 2.0 not 1.2.

<sup>101</sup> Include all resource commitments associated with the reference costs return, including reading guidance, gathering and preparing data, assurance etc. Exclude all resource commitments associated with running the costing system and producing cost information for internal use. Do not count weekends or other non-working days.

Q4a	Education and Training reference costs	Yes/No
Q4b	Service Line Reporting	Yes/No/n/a
Q4c	PLICS (locally used)	Yes/No/n/a
Q4d	PLICS (national non-mandatory collection)	Yes/No/n/a
Q4e	Other	Please specify here
Q5	What is the level of clinical and financial engagement in your organisation? <sup>102</sup>	<ul style="list-style-type: none"> <li>• Level 1</li> <li>• Level 2</li> <li>• Level 3</li> <li>• Level 4</li> </ul>
Q6	Who is the supplier of your PLICS?	<ul style="list-style-type: none"> <li>• Allocate</li> <li>• Ardentia</li> <li>• Belvan</li> <li>• Bellis-Jones Hill / Prodacapo</li> <li>• CACI/BPlan</li> <li>• Civica</li> <li>• Costflex</li> <li>• Healthcost</li> <li>• Internally provided</li> <li>• Powerhealth</li> <li>• Other supplier - please specify in Q25</li> <li>• Not yet chosen</li> <li>• N/A – not planning to implement PLICS</li> </ul>
Q7	Have you used the materiality and quality score (MAQS) as detailed in the HFMA clinical costing standards?	<ul style="list-style-type: none"> <li>• Yes/No</li> </ul>
Q8	If you answered yes to Q7, what is your current MAQS? (Voluntary)	[0-100%]

	<b>Implemented: trusts which have implemented PLICS only</b>	
Q9	How often are you producing and reporting patient level cost information?	<ul style="list-style-type: none"> <li>• Every two weeks</li> <li>• Every month</li> <li>• Every quarter</li> <li>• Twice a year</li> <li>• Annually</li> <li>• Not reporting</li> <li>• Other – please specify in Q25</li> </ul>
Q10	Did you use PLICS to support your reference costs return?	<ul style="list-style-type: none"> <li>• Yes/No</li> </ul>

<sup>102</sup> This refers to the levels of clinical and financial engagement across the whole organisation and not solely in respect of reference costs. The expectation is that finance professionals should engage with clinicians to reach an agreed level rating for the organisation, rather than finance departments establishing the level of engagement in isolation. *Effective Clinical and Financial Engagement: A Best Practice Guide to the NHS (2013)*, available at <https://www.gov.uk/government/publications/nhs-clinical-and-financial-engagement-best-practice>, includes a self-assessment tool to support trusts in making an objective assessment of their level of engagement, characteristics and behaviours of the top performing organisations, and examples of best practice.

Q11	If you answered yes to Q10, which service areas in your reference costs return were supported by PLICS? (answer n/a if you don't provide the service)	
Q11a	Admitted patient care	• Yes/No/n/a
Q11b	Outpatient services	• Yes/No/n/a
Q11c	Emergency medicine	• Yes/No/n/a
Q11d	Chemotherapy and radiotherapy	• Yes/No/n/a
Q11e	Critical care	• Yes/No/n/a
Q11f	Diagnostic imaging	• Yes/No/n/a
Q11g	High cost drugs	• Yes/No/n/a
Q11h	Rehabilitation	• Yes/No/n/a
Q11i	Specialist palliative care	• Yes/No/n/a
Q11j	Renal dialysis	• Yes/No/n/a
Q11k	Direct access services	• Yes/No/n/a
Q11l	Mental health services	• Yes/No/n/a
Q11m	Community services	• Yes/No/n/a
Q11n	Cystic fibrosis	• Yes/No/n/a
Q12	If you answered no to Q10, is there a particular reason for this?	<ul style="list-style-type: none"> <li>• System not fully developed and tested</li> <li>• Differences in reference costs and PLICS methodology</li> <li>• Data quality issues</li> <li>• Other - please specify in Q25</li> </ul>
Q13	Did you use the HFMA clinical costing standards as part of your PLICS implementation?	<ul style="list-style-type: none"> <li>• Fully</li> <li>• Partially</li> <li>• Not at all</li> </ul>
Q14	If you did not use the HFMA clinical costing standards as part of your implementation, have you subsequently reviewed your system against the standards?	• Yes/No
Q15	Did you use the HFMA clinical costing standards when producing your reference costs?	• Yes/No
Q16	If you answered no to Q13, why are you not using the HFMA clinical costing standards?	<ul style="list-style-type: none"> <li>• Our PLICS does not support them</li> <li>• We were not aware of them</li> <li>• Other - please specify in Q25</li> </ul>
Q17	When was your PLICS implemented?	<ul style="list-style-type: none"> <li>• Before 2006</li> <li>• [Year 2006 to 2015]</li> </ul>
	<b>Implementing: trusts which are currently implementing PLICS only</b>	
Q18	What stage of implementation are you at?	<ul style="list-style-type: none"> <li>• Completed and improving accuracy</li> <li>• Dual running with existing costing system</li> <li>• Supplier chosen</li> </ul>

Q19	What is your timescale for completing PLICS implementation?	<ul style="list-style-type: none"> <li>• Within 1 year</li> <li>• 1-2 years</li> <li>• 2-3 years</li> <li>• 3 years +</li> </ul>
Q20	How involved have clinicians been in implementing PLICS?	<ul style="list-style-type: none"> <li>• Level 1</li> <li>• Level 2</li> <li>• Level 3</li> <li>• Level 4</li> </ul>
Q21	Are you using the HFMA clinical costing standards as part of your PLICS implementation?	<ul style="list-style-type: none"> <li>• Fully</li> <li>• Partially</li> <li>• Not at all</li> </ul>
Q22	If you are not using the HFMA clinical costing standards why is this?	<ul style="list-style-type: none"> <li>• Our PLICS does not support them</li> <li>• We were not aware of them</li> <li>• Other - please specify in Q25</li> </ul>

	<b>Planning: trusts which are planning to implement PLICS only</b>	
Q23	What is your timescale for completing PLICS implementation?	<ul style="list-style-type: none"> <li>• Within 1 year</li> <li>• 1-2 years</li> <li>• 2-3 years</li> <li>• 3 years +</li> </ul>

	<b>No plans: trusts which are not planning to implement PLICS only</b>	
Q24	If you not planning to implement PLICS, what are the main reasons why not?	<ul style="list-style-type: none"> <li>• Financial cost of system</li> <li>• Lack of staff resource</li> <li>• Focusing on SLR</li> <li>• Not convinced of benefits to our organisation</li> <li>• Implementing new information systems</li> <li>• On-going strategic review of benefits</li> <li>• Future of organisation is uncertain</li> </ul>

	<b>All trusts</b>	
Q25	Do you have any other comments?	[Free text]

## Annex A: Respondents to draft guidance

LINCOLNSHIRE COMMUNITY HEALTH SERVICES TRUST  
 AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST  
 QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST  
 WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST  
 CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST  
 SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST  
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST  
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST  
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST  
HUMBER NHS FOUNDATION TRUST  
WEST LONDON MENTAL HEALTH NHS TRUST  
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST  
LANCASHIRE CARE NHS FOUNDATION TRUST  
THE ROTHERHAM NHS FOUNDATION TRUST  
GLOUCESTERSHIRE CARE SERVICES NHS TRUST  
NORTH EAST LONDON NHS FOUNDATION TRUST  
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST  
OXFORD UNIVERSITY HOSPITALS NHS TRUST  
THE WALTON CENTRE NHS FOUNDATION TRUST  
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST  
THE ROYAL MARSDEN NHS FOUNDATION TRUST  
MERSEY CARE NHS TRUST  
NORTH BRISTOL NHS TRUST  
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST  
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST  
YORKSHIRE AND HUMBER COSTING FORUM  
BOLTON NHS FOUNDATION TRUST  
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST  
THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST  
SHROPSHIRE COMMUNITY HEALTH NHS TRUST  
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST  
PORTSMOUTH HOSPITALS NHS TRUST  
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST  
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST  
LONDON MH TARIFF PROGRAMME on behalf of EAST LONDON NHS FOUNDATION TRUST  
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST  
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST  
NORTH BRISTOL NHS TRUST  
EAST AND NORTH HERTFORDSHIRE NHS TRUST



## Annex B: Submission deadlines

Monday 27 July 2015 – London

BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST  
 BARNET AND CHASE FARM HOSPITALS NHS TRUST  
 BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST  
 BARTS HEALTH NHS TRUST  
 CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST  
 CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST  
 CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST  
 CROYDON HEALTH SERVICES NHS TRUST  
 EALING HOSPITAL NHS TRUST  
 EAST LONDON NHS FOUNDATION TRUST  
 EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST  
 GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST  
 GUY'S AND ST THOMAS' NHS FOUNDATION TRUST  
 HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST  
 HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST  
 IMPERIAL COLLEGE HEALTHCARE NHS TRUST  
 KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST  
 KINGSTON HOSPITAL NHS FOUNDATION TRUST  
 LEWISHAM AND GREENWICH NHS TRUST  
 LONDON AMBULANCE SERVICE NHS TRUST  
 LONDON NORTH WEST HEALTHCARE NHS TRUST  
 MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST  
 NHS DIRECT NHS TRUST  
 NORTH EAST LONDON NHS FOUNDATION TRUST  
 NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST  
 NORTH WEST LONDON HOSPITALS NHS TRUST  
 OXLEAS NHS FOUNDATION TRUST  
 ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST  
 ROYAL FREE LONDON NHS FOUNDATION TRUST  
 ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST  
 SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST  
 SOUTH LONDON HEALTHCARE NHS TRUST  
 SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST  
 ST GEORGE'S HEALTHCARE NHS TRUST  
 TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST  
 THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST  
 THE ROYAL MARSDEN NHS FOUNDATION TRUST  
 THE WHITTINGTON HOSPITAL NHS TRUST  
 UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST  
 WEST LONDON MENTAL HEALTH NHS TRUST  
 WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST

Tuesday 28 July 2015 –South of England

2GETHER NHS FOUNDATION TRUST  
 ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST  
 AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST  
 BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST  
 BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST  
 BUCKINGHAMSHIRE HEALTHCARE NHS TRUST  
 CORNWALL PARTNERSHIP NHS FOUNDATION TRUST  
 DARTFORD AND GRAVESHAM NHS TRUST  
 DEVON PARTNERSHIP NHS TRUST  
 DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST  
 DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST  
EAST SUSSEX HEALTHCARE NHS TRUST  
FRIMLEY HEALTH NHS FOUNDATION TRUST  
GLOUCESTERSHIRE CARE SERVICES NHS TRUST  
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST  
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST  
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST  
HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST  
ISLE OF WIGHT NHS TRUST  
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST  
KENT COMMUNITY HEALTH NHS TRUST  
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST  
MEDWAY NHS FOUNDATION TRUST  
NORTH BRISTOL NHS TRUST  
NORTHERN DEVON HEALTHCARE NHS TRUST  
OXFORD HEALTH NHS FOUNDATION TRUST  
OXFORD UNIVERSITY HOSPITALS NHS TRUST  
OXLEAS NHS FOUNDATION TRUST  
PLYMOUTH HOSPITALS NHS TRUST  
POOLE HOSPITAL NHS FOUNDATION TRUST  
PORTSMOUTH HOSPITALS NHS TRUST  
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST  
ROYAL BERKSHIRE NHS FOUNDATION TRUST  
ROYAL CORNWALL HOSPITALS NHS TRUST  
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST  
ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST  
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST  
ROYAL UNITED HOSPITAL BATH NHS TRUST  
SALISBURY NHS FOUNDATION TRUST  
SOLENT NHS TRUST  
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST  
SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST  
SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST  
SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST  
SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST  
SOUTHERN HEALTH NHS FOUNDATION TRUST  
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST  
SURREY AND SUSSEX HEALTHCARE NHS TRUST  
SUSSEX COMMUNITY NHS TRUST  
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST  
TAUNTON AND SOMERSET NHS FOUNDATION TRUST  
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST  
TORBAY AND SOUTHERN DEVON HEALTH AND CARE NHS TRUST  
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST  
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST  
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST  
WESTON AREA HEALTH NHS TRUST  
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Wednesday 29 July 2015 –Midlands and East of England

BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST  
BEDFORD HOSPITAL NHS TRUST  
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST  
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST  
BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST  
BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST  
BURTON HOSPITALS NHS FOUNDATION TRUST  
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST  
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST

CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST  
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST  
COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST  
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST  
DERBY HOSPITALS NHS FOUNDATION TRUST  
DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST  
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST  
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST  
EAST AND NORTH HERTFORDSHIRE NHS TRUST  
EAST MIDLANDS AMBULANCE SERVICE NHS TRUST  
EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST  
GEORGE ELIOT HOSPITAL NHS TRUST  
HEART OF ENGLAND NHS FOUNDATION TRUST  
HERTFORDSHIRE COMMUNITY NHS TRUST  
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST  
HINCHINGBROOKE HEALTH CARE NHS TRUST  
IPSWICH HOSPITAL NHS TRUST  
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST  
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST  
LEICESTERSHIRE PARTNERSHIP NHS TRUST  
LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST  
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST  
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST  
MID ESSEX HOSPITAL SERVICES NHS TRUST  
MID STAFFORDSHIRE NHS FOUNDATION TRUST  
MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST  
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST  
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST  
NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST  
NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST  
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST  
NORTHAMPTON GENERAL HOSPITAL NHS TRUST  
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST  
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST  
NOTTINGHAMSHIRE HEALTHCARE NHS TRUST  
PAPWORTH HOSPITAL NHS FOUNDATION TRUST  
PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST  
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST  
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST  
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST  
SHROPSHIRE COMMUNITY HEALTH NHS TRUST  
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST  
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST  
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST  
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST  
STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST  
THE DUDLEY GROUP NHS FOUNDATION TRUST  
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST  
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST  
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST  
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST  
THE ROYAL WOLVERHAMPTON NHS TRUST  
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST  
UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST  
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST  
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST  
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST  
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST  
WALSALL HEALTHCARE NHS TRUST  
WEST HERTFORDSHIRE HOSPITALS NHS TRUST  
WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST  
WEST SUFFOLK NHS FOUNDATION TRUST  
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

**WORCESTERSHIRE HEALTH AND CARE NHS TRUST  
WYE VALLEY NHS TRUST**

Thursday 30 July 2015 – North of England

**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST  
5 BOROUGH PARTNERSHIP NHS FOUNDATION TRUST  
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST  
AIREDALE NHS FOUNDATION TRUST  
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST  
BARNSELY HOSPITAL NHS FOUNDATION TRUST  
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST  
BOLTON NHS FOUNDATION TRUST  
BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST  
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST  
CALDERSTONES PARTNERSHIP NHS FOUNDATION TRUST  
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST  
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST  
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST  
COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST  
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST  
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST  
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST  
EAST CHESHIRE NHS TRUST  
EAST LANCASHIRE HOSPITALS NHS TRUST  
GATESHEAD HEALTH NHS FOUNDATION TRUST  
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST  
HARROGATE AND DISTRICT NHS FOUNDATION TRUST  
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST  
HUMBER NHS FOUNDATION TRUST  
LANCASHIRE CARE NHS FOUNDATION TRUST  
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST  
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST  
LEEDS COMMUNITY HEALTHCARE NHS TRUST  
LEEDS TEACHING HOSPITALS NHS TRUST  
LIVERPOOL COMMUNITY HEALTH NHS TRUST  
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST  
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST  
MERSEY CARE NHS TRUST  
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST  
MID YORKSHIRE HOSPITALS NHS TRUST  
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST  
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST  
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST  
NORTH WEST AMBULANCE SERVICE NHS TRUST  
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST  
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST  
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST  
PENNINE ACUTE HOSPITALS NHS TRUST  
PENNINE CARE NHS FOUNDATION TRUST  
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST  
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST  
SALFORD ROYAL NHS FOUNDATION TRUST  
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST  
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST  
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST  
SOUTH TYNESIDE NHS FOUNDATION TRUST  
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST  
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST  
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST  
STOCKPORT NHS FOUNDATION TRUST**

TAMESIDE HOSPITAL NHS FOUNDATION TRUST  
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST  
THE CHRISTIE NHS FOUNDATION TRUST  
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST  
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST  
THE ROTHERHAM NHS FOUNDATION TRUST  
THE WALTON CENTRE NHS FOUNDATION TRUST  
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST  
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST  
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST  
WIRRAL COMMUNITY NHS TRUST  
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST  
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST  
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST  
YORKSHIRE AMBULANCE SERVICE NHS TRUST

# Annex C: Renal transplantation

## Introduction

1. Nationally specified currencies exist for adult renal (kidney) transplants. The currencies are made up of three components of the care pathway using existing HRGs, which are also applicable to child transplants, as follows:
  - (a) preparation for transplantation outpatient attendances
    - LA10\* Live donor screening
    - LA11\* Kidney pre-transplantation work-up - live donor
    - LA12\* Kidney pre-transplantation work-up of recipient,
  - (b) the transplant episode including post discharge drugs
    - LA01\* Kidney Transplant from Cadaver non-heart beating donor
    - LA02\* Kidney Transplant from Cadaver heart beating donor
    - LA03\* Kidney Transplant from Live donor
    - LB46\* Live Donation of Kidney, and
  - (c) post-transplantation outpatients
    - LA13\* Examination for post-transplantation of Kidney
    - LA14\* Examination for post-transplantation of Kidney of live donor
2. We recognise that clinical coding is not nationally mandated when a procedure takes place in an outpatient setting and, unless locally mandated, pre and post-transplant HRGs may not be automatically generated. It may be necessary to liaise with the renal unit to manually adjust activity where appropriate to reflect the fact that this pre and post-transplant activity is taking place. We would encourage this issue to be raised with renal clinicians and the clinical coding team to ensure the activity is accurately coded in future. The separate reporting of activity (and costs) against these pre and post-transplant HRGs is essential to recognise the fact that non-transplanting units may undertake this activity but not the transplant itself.
3. Where a kidney is rejected by a patient after discharge from hospital (the inpatient transplant episode), and readmission is required, a new spell of care should be recorded.
4. NHS Blood and Transplant (NHSBT) record all kidney transplants in real time. Trusts should use this information, available from a trust's renal transplant unit, as a validation check against reference cost activity.
5. As far as possible, costs related to pre and post-transplant activity should not be included within the composite cost of the transplant episode (recipient or donor), but identified and reported separately in HRGs LA10\* to LA12\* and LA13\* to LA14\* respectively.
6. All trusts submitting these costs should read *Developing robust reference costs for kidney transplants*<sup>103</sup>, published by NHS Kidney Care as a March 2010 report and August 2011 update. It includes a bottom up costing template and a number of basic rules:

<sup>103</sup> <http://www.kidneycare.nhs.uk/Resourcestodownload-Reports.aspx#Developing%20robust%20ref%20costs%20for%20kid%20transplants%20update>

- (a) kidney transplants from deceased donors (HRGs LA01\* and LA02\*) are carried out as non-electives
- (b) kidney transplants from live donors (LA03\*) are carried out as electives
- (c) non-elective short stays are very unlikely.

## Preparation for transplantation

7. All pre-transplantation outpatient activity, related to both recipient and any potential living donor, should be recorded against the appropriate LA10\* to LA12\* HRG each time the patient is seen within an outpatient clinic, including adult initial assessment and maintenance (i.e. whilst being maintained on the transplant waiting list).
8. All relevant costs should be included, as follows (this is not an exhaustive list):
  - (a) Initial assessment clinic (suitability for transplant), including:
    - (i) Cardiology tests (echocardiogram, ECG, angiogram, exercise ECG)
    - (ii) Nuclear medicine tests (stress MIBI)
    - (iii) Microbiology tests
    - (iv) Registration on local kidney transplant waiting list
    - (v) Registration on ODT (UK Transplant) kidney transplant waiting list
  - (b) Follow up outpatient activity whilst maintaining patient on the list (whilst awaiting transplant), including
    - (i) Cardiology tests (echocardiogram, ECG, angiogram, exercise ECG)
    - (ii) Vascular lab tests (duplex scans)
    - (iii) Nuclear medicine tests (stress MIBI)
    - (iv) Pathology (FBC, clotting screen)
    - (v) Radiology (chest x-ray, CT abdo, abdo ultrasound).

## Transplant inpatient episodes

9. The HRGs related to the transplant inpatient episode will be automatically generated through the Grouper and all relevant costs should be included, as follows (this is not an exhaustive list):
  - (a) pre-operative checks and tests,
  - (b) the kidney transplant procedure (in theatre,)
  - (c) any required readmission to theatre (whilst the patient is still in hospital),
  - (d) all post-operative inpatient care,
  - (e) stent removal, or
  - (f) up to 90 days post-transplant drugs.
10. The cost of kidney transplants (recipient) should also include the costs incurred of matching to suitable donors. Costs relating to a deceased donor should be included in the composite costs of the relevant recipient HRGs (LA01\* and LA02\*). Costs related to live donors should be included as part of the relevant donor HRG.
11. Costs related to the retrieval of organs from deceased donor organs are the responsibility of NHSBT and should not be included within the transplant HRG cost.
12. Currencies for antibody incompatible recipient transplantation are still in



development. Activity and costs related to these complex transplants should not be included within the transplant HRGs LA01\* to LA03\* HRGs.

## Post-transplantation outpatients

13. All post-transplantation outpatient activity, related to both recipient and any potential living donor, should be recorded against the appropriate HRGs LA13\* to LA14\*, each time the patient is seen within an outpatient clinic, including annual reviews. Relevant costs include all relevant pathology tests and antibody monitoring.

## Annex D: Changes following consultation

1. Following feedback from a number of trusts and discussion with NHS England we have taken the decision to move the collection of Improving Access to Psychological Therapies (IAPT) and Secure Forensic Services on a cluster basis to 2015-16.
2. There were a number of incidents of incorrect years and non-working links in the draft guidance; these should all now be resolved.
3. We have added a further Annex (Annex E) which is a summary of the key changes to the reference costs grouper, kindly provided by colleagues at HSCIC.
4. Minor changes to the mandatory reference costs survey.
  - (a) We have added an 'n/a' option to question 11 a-n, this option should be chosen where you do have a PLICS system but you don't provide the relevant service in your trust.
  - (b) We have added a question to find out what, if any, other cost collections your team is responsible for.

## Annex E: Summary of key changes in the reference costs grouper for 2014-15

Please note that full details of design changes can be found in the documentation that accompanies each Grouper release by the National Casemix Office.

Title	Summary
Subchapter AA	<ul style="list-style-type: none"> <li>The procedure-driven HRGs within Subchapter AA have been redesigned to include multiple procedure logic and paediatric splits where appropriate. This has also entailed an update to the Complications and Comorbidity (CC) list to accommodate CCs associated with surgery, in particular paediatric surgery.</li> <li>The redesign also allows for procedure-specific HRGs for procedures that include high cost devices.</li> <li>Care should be taken when costing these HRGs that the relevant and appropriate device costs are included in the costs reported for the Core HRG.</li> </ul>
Subchapter AB	<ul style="list-style-type: none"> <li>The pain management HRGs have been redesigned to be procedure-specific to more appropriately reflect the expected cost difference between HRGs.</li> <li>The use of pain diagnosis checks has been reviewed and standardised at the HRG level, with Length of stay checks (LoS=0) being added to the majority of HRGs, to reflect that longer-stay patients would not usually be treated specifically for the management of pain but for the pain-associated condition. This ensures that the HRGs more appropriately capture pain management activity and identifies the difference in resource usage of the various treatments.</li> </ul>
Subchapter BZ	<ul style="list-style-type: none"> <li>The procedure-driven HRGs have been redesigned to include multiple procedure logic, interactive CCs and atypical (child) age splits, to better reflect the resources associated with this clinical treatment, especially when dealing with the most complex patients.</li> </ul>
Subchapter DZ	<ul style="list-style-type: none"> <li>The current bronchoscopy HRGs have been redesigned to reflect the resource use of high cost devices, particularly in relation to distinguishing between treatments that are diagnostic or therapeutic in nature. In addition, the therapeutic HRGs now reflect the different levels of patient complexity.</li> <li>Care should be taken when costing these HRGs that the relevant and appropriate device costs are included in the costs reported for the Core HRG.</li> </ul>

Title	Summary
Chapter E	<ul style="list-style-type: none"> <li>• The procedure-driven HRGs within Subchapter EA have been redesigned to differentiate between open surgical procedures (performed by surgeons) and interventional cardiology (traditionally performed by cardiologists) and also to include multiple procedure logic and interactive complications and comorbidities (CCs). Thus Subchapter EA has been replaced by Subchapters ED for cardiac surgery for acquired conditions and EY Coronary Interventions.</li> <li>• The redesign now also provides improved recognition of the impact of undertaking multiple procedures on patients, as well as more appropriately accommodating high cost devices.</li> <li>• Care should be taken when costing these HRGs that the relevant and appropriate device costs are included in the costs reported for the Core HRG.</li> </ul>
Subchapter FZ	<ul style="list-style-type: none"> <li>• A new HRG has been created for maintenance (adjusting) of gastric bands to reflect the fact that this is now clinically, typically, a non-surgical minimally invasive procedure, often done in an outpatient setting.</li> </ul>
Chapter H	<ul style="list-style-type: none"> <li>• The Orthopaedic Subchapters, relating to both surgical and medical interventions and treatments, have been completely redesigned. The existing Subchapters have been replaced with new Subchapters that better reflect current clinical practice, and offer more transparency in terms of how the HRGs recognise the additional resource use of treating patients with trauma, malignancy and infection, as well as for complex specialised surgery.</li> <li>• The redesign now also provides improved recognition of the impact of undertaking multiple procedures on patients, as well as more appropriately accommodating high cost devices, and recognising the additional resources incurred when operating on children.</li> <li>• In addition, the Spinal Surgery (extradural) HRGs and those relating to Spinal Reconstruction have been reviewed and refined to better reflect the additional resource use of treating patients with malignancy, and those that are children.</li> <li>• Care should be taken when costing these HRGs that the relevant and appropriate device costs are included in the costs reported for the Core HRG.</li> </ul>
Subchapter NZ	<ul style="list-style-type: none"> <li>• New HRGs have been created to differentiate resource usage between complex and routine fetal medicine, to better align with policy requirements relating to the identification of Nationally Prescribed Specialised Services.</li> </ul>
Subchapter PB	<ul style="list-style-type: none"> <li>• The PB01Z Major Neonatal Diagnoses and PB02Z Minor Neonatal Diagnoses have been redesigned to include recognition of source of admission (Tertiary, From Home, or treated continuously by same hospital since birth), as well as complication and comorbidity (CC) splits and intervention splits, where clinically appropriate.</li> </ul>

Title	Summary
Subchapters PQ and PX	<ul style="list-style-type: none"> <li>• A new Subchapter, PQ, has been created for immunological conditions.</li> <li>• Subchapter PX has also been redesigned to better reflect congenital conditions in children, specific to body-systems.</li> </ul>
Subchapter RA	<ul style="list-style-type: none"> <li>• This Subchapter has been deleted and replaced with two new subchapters RN (nuclear medicine) and RD (diagnostic imaging) to ensure that the differing resources for diagnostic imaging and nuclear medicine are appropriately recognised.</li> <li>• This redesign also sees an improved identification of complex scans, as well as a more standardised acknowledgement of the additional resource use of treating patients who are children.</li> </ul>
Subchapter SA	<ul style="list-style-type: none"> <li>• The HRG SA28 (PBSCT-Allogeneic) now further differentiates on donor type, to better acknowledge the additional resources incurred in identifying donors for this high cost service.</li> </ul>
Subchapter VB	<ul style="list-style-type: none"> <li>• A new HRG has been created specifically to capture the resource use for patients who are dead on arrival at emergency departments.</li> </ul>
Subchapter WA	<ul style="list-style-type: none"> <li>• The existing single Subchapter has been redesigned and replaced with two new Subchapters (WH and WJ) differentiating between Immunology and Infectious Diseases, and more miscellaneous and generalised conditions, to better reflect the nature of the clinical care provided, and the conditions for which patients are receiving treatment.</li> </ul>
Chapter Y	<ul style="list-style-type: none"> <li>• Reference Costs 2014/15 sees the completion of the second phase of the redesign of Interventional Radiology Core HRGs.</li> <li>• The “holding” Subchapter YZ has been removed, with patient activities being mapped to newly created Subchapters that better reflect the treatment of body-systems, beyond those specific to Vascular Imaging Interventions.</li> <li>• New Subchapters have been created for clinical areas including: <ul style="list-style-type: none"> <li>○ YA Neurological Imaging Interventions</li> <li>○ YD Thoracic Imaging Interventions</li> <li>○ YF Gastrointestinal Imaging Interventions</li> <li>○ YG Hepatobiliary/Pancreatic Imaging Interventions</li> <li>○ YH Musculoskeletal Imaging Interventions</li> <li>○ YJ Breast Imaging Interventions</li> <li>○ YL Urological Imaging Interventions.</li> </ul> </li> <li>• It should be noted that the anticipated movement of activity as a result of this redesign may also affect Subchapters not currently specific to Interventional Radiology or Imaging Interventions.</li> <li>• Care should be taken when costing these HRGs that the relevant and appropriate theatre costs are included in the costs reported for the Core HRG.</li> </ul>

## Annex F: Flow Chart Written Description

This annex provides a written description of figure 1 to 7 to assist those with visual impairments to access this material.

### Figure 1: Reporting chemotherapy ordinary admissions

There are 3 boxes in the flow diagram. The first box in the diagram indicates the core HRG that would be reported in an elective or non-elective sheet. The second box indicates the chemotherapy procurement HRG that is generated. The final box in the flow is crossed out to indicate that there is no chemotherapy delivery HRG generated as OPCS chemotherapy delivery codes are not recorded.

### Figure 2: Reporting chemotherapy day cases and regular day or night attenders

There are 3 boxes in the flow diagram. The 1<sup>st</sup> box indicates the core HRG SB97Z that would be generated for patients admitted for same day chemotherapy treatment if no other significant procedure has taken place. This has zero cost associated to it. The 2<sup>nd</sup> box in the flow diagram indicates the unbundling of the chemotherapy procurement HRG from core HRG where the procurement cycle is recorded, this need to be recorded separately. The final box in the flow diagram indicates the unbundling of the deliver HRG from the core HRG that would recorded, this also needs to be recorded separately.

### Figure 3: Reporting chemotherapy outpatients

There are 3 boxes in the flow diagram. The 1<sup>st</sup> box indicates the core HRG SB97Z that will be generated for outpatients attending solely for delivery of chemotherapy. This HRG has no associated costs. The 2<sup>nd</sup> box indicates the unbundling of chemotherapy procurement HRG from the core HRG, where the procurement cycle is recorded, this needs to be recorded separately. The final box indicates the unbundling of chemotherapy delivery HRG from the core HRG this also needs to be recorded separately.

### Figure 4: Reporting rehabilitation services

There are flow diagram has 3 steps each step proposing a question. The 1<sup>st</sup> step in the diagram poses the question 'what happens to the patient', the flow diagram states the patient has hip replacement which took 10 days and then the patient has discrete rehabilitation as part of the admission for 20 days. The total length of stay for the spell is 30 days.

The next step in the flow diagram proposes the question 'what does the grouper output?' The flow diagram states one core HRG is reported for the ordinary admission worksheet for the hip replacement and 20 unbundled HRG's are reported for the rehabilitation on the rehabilitation worksheet.

The final step in the flow diagram proposes the question, 'what cost should be reported and where?' The flow diagram states the core HRG generated from the ordinary admission should be recorded for 10 days and any excess days if applicable and 20 days for the unbundled HRG's to be reported in the rehabilitation worksheet.

### Figure 5: Reporting patient contacts with multi-disciplinary community mental health teams

The flow chart has 4 flows to show how the reporting of patient contacts should take place. The first row of boxes indicates the discipline meetings, it shows 9 discipline meetings.

The next flow indicates the number of patients in each discipline meeting. The first discipline has 1 patient. The 2<sup>nd</sup> and 3<sup>rd</sup> same discipline have the same 1 patient. The 4<sup>th</sup> and 5<sup>th</sup> discipline meeting has 2 patients but both attending the 4<sup>th</sup> and 5<sup>th</sup> discipline meeting. The 6<sup>th</sup> and 7<sup>th</sup> different discipline meeting has the same 1 patient. The 8<sup>th</sup> and 9<sup>th</sup> different discipline meeting has 2 patients but both attending the 8<sup>th</sup> and 9<sup>th</sup> discipline meeting.

The 3<sup>rd</sup> flow shows the professionals of each discipline;

- Same discipline -1 professional,
- Same discipline – 2 professionals,
- Same discipline – 2 professionals,
- Different discipline – 2 professionals,
- Different discipline – 2 professionals.

The 4<sup>th</sup> flow shows how the contact should be report

- If the discipline meeting has 1 patient and 1 profession from the same discipline 1 patient contact should be recorded
- If there are 2 discipline meetings with 1 patient and 2 same discipline professionals 1 patient contract should be recorded
- If there are 2 discipline meetings with 2 patients each seen by each discipline meeting with 2 same discipline professionals 2 patient contacts should be recorded.
- If there are two different disciplines meeting with 1 patient and 2 different discipline professionals 2 patient contacts should be recorded.
- If there are 2 different discipline meetings with 2 patients each seen by each discipline meeting with 2 different discipline professionals 4 patient contacts should be recorded.
- The exception to this general principle is when two or more professionals from the same discipline meet a single patient, at the same time, but for a different purpose (Figure 6).

### Figure 6: Reporting patient contacts with two or more professionals from the same discipline

The flow chart has 4 flows to show how the reporting of patient contacts should take place with 2 or more professionals form the same discipline.

The 1<sup>st</sup> row of boxes indicates the discipline meetings; it shows 2 same discipline meetings

The 2nd flow shows 1 patient attending the same 2 discipline meeting.

The 3<sup>rd</sup> flow indicates same discipline with 2 professionals for different purpose



The 4<sup>th</sup> flow indicates the number of patient contacts that should be recorded.

- For 2 same discipline meetings for 1 patient with 2 professionals for the same discipline but different purpose should be recorded as 2 patient contacts.

**Figure 7: Provider to provider agreements**

The flow diagram has 3 flows, the 1<sup>st</sup> flow indicates the providing trust ( A), it indicates their income and expenditure matched and income and expenditure matched but exclude activity from their own return.

The 2<sup>nd</sup> flow indicates support services and treatment services

The 3<sup>rd</sup> flow indicates the receiving trust (B) and how they should receive services received from the providing trust (A).

- If the providing trust A is providing support services to the receiving trust B, trust A should match their income and expenditure and trust B should report costs of support service allocated/apportioned as though provided internally.
- If the providing trust A is providing treatment services to the receiving trust B, trust A should match their income and expenditure and exclude activity from their own return and trust B should report costs and activity