We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.
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Please note: This document was updated in April 2018 to clarify the board assurance requirements (paragraphs 47 and 48).
1: Introduction

Purpose and context

1. This is the final guidance for the 2018\(^1\) national cost collection (data for 2017/18 financial year). This document covers the mandatory reference cost submission for all NHS providers. It also covers acute providers’ voluntary costing transformation programme (CTP) patient-level information and costing system (PLICS) submission.

2. This guidance is part of the Approved Costing Guidance 2017/18\(^2\) and is part of NHS Improvement’s costing work. This document should be read in conjunction with the other documents in the Approved Costing Guidance.

3. On 28 September 2017 we circulated a costing bulletin that announced the next step towards a single national cost collection based on patient-level costs. For acute providers, mandatory reference costs and a voluntary PLICS cost collection will run in parallel in 2018 as a joint process with a single set of guidance and submission templates. The outputs will be reconciled for the first time. The introduction to the Approved Costing Guidance includes a list of acute providers that can submit reference costs and voluntary PLICS submissions.\(^3\)

4. If the new system works to stakeholders’ satisfaction, from 2019 we expect to have a single national cost collection for acute services underpinned by patient-level costs.

5. Table 1 gives an overview of the collections required from each provider type for 2018.

---

\(^1\) When 2018 is stated in this document it refers to the cost collection for the financial year 2017/18.

\(^2\) The Approved Costing Guidance includes the costing principles, *Healthcare costing standards for England* and a range of tools to support the costing process. The Approved Costing Guidance is available at: [https://improvement.nhs.uk/resources/approved-costing-guidance/](https://improvement.nhs.uk/resources/approved-costing-guidance/)

\(^3\) See *The Approved Costing Guidance 2018 – what you need to know and what you need to do*. [https://improvement.nhs.uk/resources/approved-costing-guidance/](https://improvement.nhs.uk/resources/approved-costing-guidance/)
6. Community, mental health and ambulance providers are required to submit reference costs only. There will be voluntary PLICS collections for those providers in 2018, but they will be collected separately from the national cost collection process.

7. If your trust delivers services in scope of the voluntary PLICS collection but is primarily a community or mental health provider, you will not be required to submit PLICS\(^4\) for those services as part of the national cost collection in 2018.

8. If you are primarily an acute trust that also delivers other services and have volunteered for the PLICS collection this year, you will be required to make a full reference costs submission and an additional PLICS submission for the services in scope for that collection.

9. Education and training (E&T) costs and the integrated (net of E&T costs) reference cost submission will not be required in 2018.

10. We are developing new standards for costing E&T and reviewing how it works alongside patient-level costing. We will pilot the new standards in 2018 with a view to integrating them into the national cost collection in 2019.

---

\(^4\) The voluntary PLICS collection will be referred to as the PLICS in the document from this point forward.
11. A transitional method\(^5\) has been developed to net off E&T income from patient care costs in a transparent way. This will be used for both PLICS and reference costs this year to ensure that the same methodology is being used by all trusts for both collections.

**Essential resources**

**Table 2: Resources needed for the national cost collection 2017/18**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Content</th>
<th>Reference costs</th>
<th>PLICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved Costing Guidance</td>
<td>This includes the national cost collection guidance and the <em>Healthcare costing standards for England</em>, which should be used when preparing the 2017/18 national cost collection return. It tells providers how to comply with the pricing conditions of NHS Improvement’s provider licence that relate to recording of costs.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Collection templates</td>
<td>There will be a single Microsoft Excel macro-enabled 2007-10 workbook (requires Excel 2007 or later to run) for the national cost collection. The workbook will incorporate a reference costs template and a template to capture reconciliation and memorandum items. The CTP PLICS data will be collected using XML/CSV files generated by costing systems.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Healthcare resource group 4+ (HRG4+) 2017/18 reference costs grouper and documentation</td>
<td>The National Casemix Office (NCO) at NHS Digital publishes the grouper and supporting documentation, including the user manual, the code to group, individual chapter summaries, and a high level summary of changes from the previous costing grouper release.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>National cost collection system and file specification guide</td>
<td>A manual to help users submit their data in SDCS for reference cost and SEFT for PLICS. This includes the files specifications for the PLICS extracts.</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

\(^5\) The transitional method is published as part of the *Healthcare costing standards for England*, within the Approved Costing Guidance. See [https://improvement.nhs.uk/resources/approved-costing-guidance-standards](https://improvement.nhs.uk/resources/approved-costing-guidance-standards)
Where possible, we will align the requirements of the transitional costs collection with the definitions in the NHS Data model and dictionary (the Data Dictionary) and include links in this guidance.

The data validation tool converts CSV files into the required PLICS collection format, assesses the data quality of the cost collection files, compresses the collection files before onward submission, and performs reconciliation checks between PLICS and reference costs.

SEFT is the method NHS providers will use to transfer PLICS data to NHS Digital electronically and securely.

The reference costs element of the collection will no longer be collected using Unify2 as the contract for Unify2 expires in March 2018. SDCS is an existing collection system used by NHS Digital. It will now be the platform to collect the reference costs element of the 2018 national cost collection.

The Terminology Reference data Update Distribution (TRUD) service supplies datasets 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, with mapping to OPCS-4 codes that relate to unbundled diagnostic imaging HRGs
- the national laboratory medicines catalogue, a national catalogue of pathology tests.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Content</th>
<th>Reference costs</th>
<th>PLICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Data Dictionary</td>
<td>Where possible, we will align the requirements of the transitional costs collection with the definitions in the NHS Data model and dictionary (the Data Dictionary) and include links in this guidance.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>NHS Improvement’s data validation tool</td>
<td>The data validation tool converts CSV files into the required PLICS collection format, assesses the data quality of the cost collection files, compresses the collection files before onward submission, and performs reconciliation checks between PLICS and reference costs.</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>SEFT (Secure Electronic File Transfer)</td>
<td>SEFT is the method NHS providers will use to transfer PLICS data to NHS Digital electronically and securely.</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>SDCS (Strategic Data Collection System)</td>
<td>The reference costs element of the collection will no longer be collected using Unify2 as the contract for Unify2 expires in March 2018. SDCS is an existing collection system used by NHS Digital. It will now be the platform to collect the reference costs element of the 2018 national cost collection.</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>The Technology Reference data Update Distribution (TRUD) datasets</td>
<td>The Terminology Reference data Update Distribution (TRUD) service supplies datasets 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, with mapping to OPCS-4 codes that relate to unbundled diagnostic imaging HRGs, the national laboratory medicines catalogue, a national catalogue of pathology tests.</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>
Main changes for 2018

12. The changes to the national cost collection in 2018 are designed to:

- support the development of price-setting
- improve data quality, validation and assurance
- ensure the collection remains fit for purpose
- support the transition to patient-level costing.

13. This is the second year we have encouraged acute providers to submit their costing transformation programme (CTP) patient-level data. With this in mind, we have aligned the reference cost and PLICS cost collections to reduce the burden on the sector and begin the transition to a single national cost collection.

14. Table 3 summarises the changes for the national cost collection in 2018.

Table 3: Changes for the 2018 national cost collection

<table>
<thead>
<tr>
<th>Change</th>
<th>Change to reference costs</th>
<th>Change to PLICS</th>
<th>For alignment with PLICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the development of price-setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E SNOMED coding:</strong> Some trusts have moved to SNOMED coding. Although we have not changed the collection of A&amp;E for 2017/18, we will include guidance to help with mapping. This will require consultation with informatics departments within trusts.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Advice and guidance activity and costs:</strong> NHS England has requested that the activity and cost for advice and guidance are collected to support the production of a tariff for the current CQUIN. During the consultation process, feedback was received that some providers can identify this activity and some cannot. We will be asking for the costs and activity as a memorandum item in the reconciliation section.</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Consultant episodes:</strong> The PLICS collection had a focus on completed and incomplete episodes within the collection year, and reference costs were based on episodes within spells that completed in the collection year. The aim is to bring the two</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Change</td>
<td>Change to reference costs</td>
<td>Change to PLICS</td>
<td>For alignment with PLICS</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------</td>
<td>-----------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>collections in line. To align the two collections we ask that finished consultant episodes (FCEs) that are completed in the collection year are submitted for reference costs and PLICS. The costs of incomplete episodes will be collected in the reconciliation statement as a memorandum item. Further guidance is contained in Section 8: Admitted patient care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Critical care:** The CC Expert Working Group has requested that the paediatric and neonatal submissions change be more in line with adult critical care. Critical care costs have been unbundled from admitted patient care in PLICS, to align the two collections. Critical care costs must be reported in the unbundled critical care sheet in the reference costs workbook only. Please see the critical care chapter for more detail.

**Gender reassignment patients:** Patients who can be identified as having gender reassignment procedures are not submitted in PLICS. To align reference costs and PLICS, the cost of these patients will be collected as a memorandum item in the reconciliation sheet in addition to the costs reported in the outpatient and admitted patient care sheets. The data will be used in the ‘RC to PLICS’ calculation worksheet.

**High cost devices:** In 2018 we will continue to exclude these devices from HRGs as some trusts do not incur the cost of devices as they are procured centrally by NHS Supply Chain. In PLICS, high cost devices will also be excluded to ensure consistency across providers. There will be a new line in the reconciliation statement in the 2018 reconciliation worksheet for these costs.

**High cost drugs:** The national cost collection requires the classification of some drugs as 'high cost'. For PLICS they are identifiable within the patient activity and for reference costs they must not form part of the HRG cost, and must be submitted separately. The list in Annex A of the national tariff will be used to identify which drugs should be classed as ‘high cost’ for both collections.

**Contracted-out (outsourced) activity:** Outsourced patient activity will no longer be collected in reference costs and PLICS collections. This is activity that is outsourced to private health providers, rather than outsourced administration services.
<table>
<thead>
<tr>
<th>Change</th>
<th>Change to reference costs</th>
<th>Change to PLICS</th>
<th>For alignment with PLICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therefore there will be a line within the reconciliation statement to exclude these costs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Well babies</strong>: PLICS will not collect well babies activity in 2018. Any well babies costs must be reported in the mother's delivery episode.</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Improve data quality, validation and assurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity pathway costs</strong>: In the 2017 cost collection we highlighted the problem of movements of patient income transactions being dealt with in the ledger. We included guidance to ensure income/cost were not part of the reference cost quantum. This will need to continue for the 2018 collection and also ensure this is taken into account in PLICS.</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>National activity dataset reconciliation</strong>: Reconciliation of submitted activity has always been a requirement of the reference cost collection. However, confirmation that this step has been done has only ever been via the checklist, then assured by the audit process. For the acute PLICS collection, the reconciliation is collected to give immediate assurance of the activity submitted. As the reconciliation is for both the reference cost and PLICS collections we propose that the national dataset reconciliation is completed and submitted to NHS Improvement as part of the reconciliation workbook.</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Non-patient activity</strong>: Income from non-patient activity has been allowable in the reference cost quantum to date, but the PLICS submission required costs of non-patient activities. Again, to align the two collections we would need to follow one methodology. We will continue to allow netting off income in reference costs in 2018, and this should also be applied to PLICS. To understand the costs for non-patient activity, we will collect the costs as a memorandum item only.</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Change

<table>
<thead>
<tr>
<th>Change to reference costs</th>
<th>Change to PLICS</th>
<th>For alignment with PLICS</th>
</tr>
</thead>
</table>

**Reconciliation statement:** We are working to ensure the reconciliation statement is for both the reference cost return and the PLICS return. We have changed the layout so that the first section of the statement relates purely to the reconciliation to the final audited accounts, and the second section relates to exclusions and adjustments for the cost collection.

**Specialist palliative care support – SD03**: This data should now be submitted per contact rather than by bed day as in previous years, see paragraph 342 for more detail.

**Ensuring the collection remains fit for purpose**

There are minor amendments to the guidance following analysis of the queries received during the 2017 submission. These include specialist palliative care and mental health initial assessments.

There are no significant changes for the mental health, community or ambulance sector. The guidance has been updated and enhanced where appropriate for 2018.

15. Providers will be required to submit the following (see Table 4) on the memorandum worksheet within the collection workbook.

16. The costs reported in the memorandum sheet will help inform future collections. This sheet does not form part of the reference cost quantum, and contains costs that are already reported elsewhere within the reference costs workbook.
### Table 4: Memorandum items to be submitted as part of the reconciliation workbook

<table>
<thead>
<tr>
<th>Memorandum items</th>
<th>Detail</th>
<th>Paragraph</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Hospital Episode Statistics (HES) activity reconciliation</strong></td>
<td>Providers are required to reconcile activity reported for admitted patient care (APC), outpatient services (OP) and accident and emergency (A&amp;E) in the reference costs workbook to HES. Providers not submitting PLICS can do so on a comply-and-explain basis. Therefore if providers have used a local data source deemed more accurate than the HES data, the variance should be explained.</td>
<td>60</td>
</tr>
<tr>
<td><strong>Advice and guidance</strong></td>
<td>To support the advice and guidance CQUIN, providers will be required to cost and report activity for this service.</td>
<td>153</td>
</tr>
<tr>
<td><strong>Gender reassignment</strong></td>
<td>To assist with future collection and tariff development we need to understand the cost and activity of gender reassignment. Providers are required to report costs and activity for gender reassignment as a memorandum item, in addition to reporting the costs in outpatient and admitted patient care sheets.</td>
<td>132</td>
</tr>
<tr>
<td><strong>Incomplete consultant episodes</strong></td>
<td>To align reference costs and PLICS, and understand the cost and activity of incomplete consultant episodes, providers will be required to report an estimation of brought-forward incomplete episodes from financial year 2016/17 and carry forward incomplete episodes for financial year 2017/18.</td>
<td>111</td>
</tr>
<tr>
<td><strong>Non-patient costs (other operating costs)</strong></td>
<td>To understand the true costs of delivering NHS services, non-patient activity costs should be netted off rather than netting off income. To understand the differentiation between non-patient income and costs, providers are required to submit non-patient costs.</td>
<td>623</td>
</tr>
</tbody>
</table>
Possible changes for 2019

17. The consultation on mandating patient patient-level costs for acute activity ran in October and November 2017.⁶

18. The outcome of the consultation was that from 2019 we will be mandating the collection of patient-level costs for acute activity from designated providers.

19. The consultation document proposed changes to the requirements on NHS foundation trusts and NHS trusts to record and report the costs of acute activity at a patient level.

20. For acute activity we proposed patient-level costs would be mandated from the financial year 2018/19 (and submitted in 2019). Other activity (such as community, mental health and ambulance services) would continue to be collected using reference costs. We plan to roll out patient-level costing to these services, subject to assessment and consultation.

21. To support the transition from reference costs to patient-level costs, the consultation proposed two years’ dual running of reference cost and patient-level cost collections (2018/19 and 2019/20).

22. The above is dependent on the outcome of the 2018 national cost collection. If PLICS is adequately reconciled to reference costs, we intend to run a single collection for the trusts and services within scope of the PLICS collection from 2019.

23. The methods and basis for costing would follow the rules set out in the standards published as part of the Approved Costing Guidance.

24. While we will try to keep the changes to the collection to a minimum, there are likely to be some changes as we continue to develop the collection:

- further refinement of the methodologies for aligning reference costs and PLICS based on lessons learned in 2018
- integration of E&T costing into the national cost collection
- continuous improvement of the PLICS collection activities and resources, based on user requirements

⁶ https://improvement.nhs.uk/resources/mandating-patient-level-costing/
possible further policy changes:
- treatment of income
- treatment of excess bed days
- treatment of incomplete episodes.

25. We will assess the unbundled services that are outside the PLICS 2017/18 scope, to see if they can be brought into the scope of PLICS 2018/19, eg critical care and chemotherapy. For A&E attendances, the new SNOMED coding may lead to HRG development that might have an implication for the reference cost collection in 2019.

26. Mental health and ambulance PLICS collections will be included in the scope of the 2019 national cost collection on a voluntary basis. This requires PLICS and reference costs for these services to be aligned for the two to reconcile. We will be working with our roadmap partners and early implementers in 2018 to develop plans to achieve this.

27. In 2018 we have changed the activity for specialist palliative care support contacts (HRG SD03*) from bed days to face-to-face, non face-to-face and advice and guidance contacts. This change only applies to providers that have captured contacts during 2017. In 2019 this will apply to all providers, so we ask providers to start collecting this information from 1 April 2018. See paragraphs 341 to 346 below for more information.
2: Scope of activity and cost data to be collected in 2018

Who needs to submit cost data?

28. In 2018, all NHS acute, community, mental health and ambulance trusts will be required to submit reference costs.

29. The Review of Central Returns Committee (ROCR)\(^7\) has previously approved this collection under reference number ROCR/OR/2132/FT6/002MAND under a three-year rolling review. It is therefore mandatory for all NHS trusts and NHS foundation trusts in existence between 1 April 2017 and 31 March 2018 to comply with this guidance and its timescales.

30. Acute trusts are also invited to take part in the CTP PLICS voluntary submission. The PLICS collection will be in the same submission window as the reference cost submission, and must reconcile to the reference cost activity and cost submission before submission is complete.

31. Ambulance, mental health and community CTP PLICS pilots will be collected separately to the national cost collection. Separate guidance for this will be published in March 2018.

Guidance for mergers and acquisitions

32. In line with the Treasury’s financial reporting manual,\(^8\) combining two or more public bodies or transferring functions from one part of the public sector to another is accounted for using absorption rather than merger accounting, as outlined below:

- Where provider A is dissolved in-year (eg on 30 June 2017) and is acquired in-year by provider B (eg on 1 July 2017), it is provider B’s responsibility to ensure a single 2017/18 national cost collection return, combining the costs

---

\(^7\) Now the Burden Advice and Assessment Service (BAAS) [http://content.digital.nhs.uk/baas](http://content.digital.nhs.uk/baas)

and activity for both providers A and B, and to submit it by the mandatory
deadline. When completing the reconciliation statement, provider B will need
to reconcile to the sum of two sets of accounts: one covering provider A from
1 April 2017 to 30 June 2017, and one covering provider B from 1 April 2017
to 30 June 2017 and trust A and B combined from 1 July 2017 to 31 March
2018.

- Where provider C is dissolved on 31 March 2017 and acquired by provider D
  on 1 April 2017, a separate costs collection return will be required for
  provider C, which will be completed by provider D in addition to provider D’s
  own return.
- Where there is a transfer of function from provider E to provider F and
  neither provider dissolves, each provider will account for the transferred
  function for the period they provided the service. The combined cost
  collection will follow the financial accounts and no adjustment will be
  required.

33. 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 costs and is not included in the reconciliation statement.

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

Guidance for new foundation trusts

35. Successful applicants for NHS foundation trust status during the financial year
    must submit one full year’s combined costs collection for the sum of the NHS
    trust costs and the NHS foundation trust costs.

Activity to be submitted in 2018

36. The collection year begins on 1 April 2017 and ends on 31 March 2018. All
    episodes, attendances and contacts completed within the collection year must
    be costed and submitted.

37. FCEs that started on or before 31 March 2017 and finished in the collection
    year must be submitted (see paragraph 111 for more guidance on the reporting
of FCEs). Contacts or attendances that started on 31 March 2017 and finished on 1 April 2017 must be submitted.

38. This is a change to inpatient activity that was collected in 2017 reference costs and CTP PLICS collection. The approach for this year is a transitional step towards costing complete and incomplete episodes in future collections.

Timetable

39. Table 5 outlines the timetable for the 2017/18 national cost collection.

**Table 5: National cost collection timetable for all sectors**

<table>
<thead>
<tr>
<th>Date (2018)</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 January</td>
<td>National cost collection guidance for 2018 published</td>
</tr>
<tr>
<td>31 January</td>
<td>Draft reference costs workbook and PLICS specification documents released</td>
</tr>
<tr>
<td>February – early March</td>
<td>Testing – reference costs workbook, PLICS specification and data quality tool</td>
</tr>
<tr>
<td>March</td>
<td>Release of HRG4+ 2017/18 reference costs grouper and documentation</td>
</tr>
<tr>
<td>April</td>
<td>Release of reference costs workbook, PLICS specification and data quality tool</td>
</tr>
<tr>
<td>18 June</td>
<td>Cost collection window opens</td>
</tr>
<tr>
<td>31 August</td>
<td>National cost collection window closes</td>
</tr>
<tr>
<td>3 September – 21 September</td>
<td>Analysis and feedback – reference costs and PLICS</td>
</tr>
<tr>
<td>24 September – 5 October</td>
<td>Resubmission period</td>
</tr>
</tbody>
</table>
Table 6 outlines the timetable for 2018 national cost collection submissions.

**Table 6: Detailed national cost collection timetable for all sectors**

<table>
<thead>
<tr>
<th>Date</th>
<th>RC</th>
<th>PLICS</th>
<th>Milestone</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 June</td>
<td></td>
<td></td>
<td>Cost collection window opens for trusts submitting RC only</td>
<td>Finance directors who are ready to sign off your submission may do so at any time from this date.</td>
</tr>
<tr>
<td>2 July</td>
<td></td>
<td>✓</td>
<td>Cost collection window opens for trusts submitting RC and PLICS</td>
<td>Finance directors that are ready to sign off your submission may do so at any time from this date.</td>
</tr>
<tr>
<td>2 July – 31 August</td>
<td>✓</td>
<td></td>
<td>Submission slots available for PLICS submission</td>
<td>The submission process for PLICS is via a timetabled slot with NHS Digital. This process is still being finalised and we will not have exact details until we know how many trusts are submitting PLICS. We will provide further detail before the collection.</td>
</tr>
<tr>
<td>24 August</td>
<td>✓</td>
<td></td>
<td>Deadline for initial reference costs submission</td>
<td>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. <strong>This is important this year as we are using SDCS for the first time.</strong></td>
</tr>
<tr>
<td>28 August</td>
<td>✓</td>
<td></td>
<td>Regional named days for final, signed-off reference costs submissions. SDCS does not include a sign-off functionality so the sign-off process will be incorporated into the workbook. It is still the London</td>
<td></td>
</tr>
<tr>
<td>29 August</td>
<td>✓</td>
<td></td>
<td>Regional named days for final, signed-off reference costs submissions. SDCS does not include a sign-off functionality so the sign-off process will be incorporated into the workbook. It is still the South</td>
<td></td>
</tr>
<tr>
<td>30 August</td>
<td>✓</td>
<td></td>
<td>Regional named days for final, signed-off reference costs submissions. SDCS does not include a sign-off functionality so the sign-off process will be incorporated into the workbook. It is still the Midlands and East North</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>RC</td>
<td>PLICS</td>
<td>Milestone</td>
<td>Notes</td>
</tr>
<tr>
<td>--------------------</td>
<td>----</td>
<td>-------</td>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>31 August</td>
<td>✔</td>
<td>✔</td>
<td>National cost collection window closes</td>
<td>RC submissions to SDCS not available after this date. No further PLICS submission slots after this date.</td>
</tr>
<tr>
<td>3 September – 21 September</td>
<td>✔</td>
<td>✔</td>
<td>Analysis and feedback</td>
<td>The central collections teams will analyse the RC and PLICS submissions during this window and will get in touch with any trusts where a resubmission is required.</td>
</tr>
<tr>
<td>24 September – 5 October</td>
<td>✔</td>
<td>✔</td>
<td>Resubmission window</td>
<td>During this window any trusts where we have found data quality issues or trusts (for PLICS) have requested a resubmission will be required to resubmit their data.</td>
</tr>
</tbody>
</table>
3: Regulatory requirements and standards

Background

41. Foundation trusts and NHS trusts are required to submit their national cost collection returns in accordance with the Approved Costing Guidance.  

42. The requirements include the seven costing principles:

- stakeholder engagement
- consistency
- data accuracy
- materiality
- causality and objectivity
- transparency
- totality.

43. The national cost collection guidance therefore constitutes the ‘approved reporting currencies’ and ‘approved guidance’ – the guidance NHS foundation trusts and NHS trusts must apply to the recording and allocation of costs, in accordance with the provider licence (for foundation trusts) and the accountability framework (for NHS trusts).

External assurance and enforcement

44. National cost collection submissions are subject to audit as part of the costing assurance audit programme and all acute NHS trusts and foundation trusts will be selected for audit at least once every three years. The purpose of the audit programme is to provide assurance that reference costs have been prepared in accordance with the Approved Costing Guidance.

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9 https://improvement.nhs.uk/resources/approved-costing-guidance-collections
45. For 2017/18, NHS Improvement will provide assurance that reference costs and/or PLICS have been prepared in accordance with the Approved Costing Guidance.

46. NHS Improvement has enforcement powers that may be used where providers have not prepared reference costs submissions in accordance with the Approved Costing Guidance.

Board approval and sign-off

47. The board of each NHS trust and NHS foundation trust, or its audit committee or other appropriate sub-committee, is required to confirm the following in relation to the reference cost return (or provide details of non-compliance):

- the board or its appropriate sub-committee has approved the costing process ahead of the collection
- the finance director has, on behalf of the board, approved the final national costs collection return before the final submission
- the return has been prepared in accordance with the Approved Costing Guidance,\(^{10}\) which includes the national costs collection guidance
- information, data and systems underpinning the national costs collection return are reliable and accurate
- there are proper internal controls over the collection and reporting of the information included in the national costs collection, and these controls are subject to review to confirm that they are working effectively in practice
- costing teams are appropriately resourced to complete the national costs collection return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the guidance.

48. Compliance with this requirement will form part of the costing assurance programme and may be subject to review by NHS Improvement.

49. The finance director is responsible for the accurate completion of the 2018 national cost collection return. The submission should be subjected to the same scrutiny and diligence as any other financial returns submitted by the provider.

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\(^{10}\) [https://improvement.nhs.uk/resources/approved-costing-guidance/](https://improvement.nhs.uk/resources/approved-costing-guidance/)
50. The finance director will be required to sign off your final data before submission.

51. SDCS, the new collection system for reference costs, does not have the same sign-off functionality as Unify2 had, so the sign-off process will now be contained within the collection workbook.

52. Unlike in Unify2 your finance director will not require log-in details to sign off the submission. It is, however, mandatory for them to agree your final submission, and this will be by selecting a tick box in the workbook. As with Unify2, once a ‘ticked’ workbook is submitted you will not be able to make any further submissions to SDCS without first contacting the reference costs team.

53. We are still working through the details of this process with NHS Digital, but you will find full guidance on accessing SDCS and how the submission and sign-off process will work in the workbook and system user guide which will be released alongside the workbooks.

**PLICS: Additional sign-off information**

54. If you are submitting PLICS and reference costs, you should not make your final reference costs submission until you are confident that your PLICS data will not be changed. This is because we intend the reference costs sign-off process to act as a single sign-off for both elements of the collection.

55. There will be further guidance on how this process works, both within the reference costs workbook and in the workbook user guide.

**Self-assessment quality checklist**

56. It is the responsibility of each provider to produce sound, accurate and timely data that is right first time.

57. The self-assessment quality checklist will be in the workbooks when they are released and must be completed by all providers.
National cost collection survey

58. A survey that covers all elements of the national cost collection will be part of the collection. It will be in the workbooks and must be completed by all providers.

Activity reconciliation

59. Previously for reference costs, we asked in the self-assessment quality checklist if activity reconciliation had been completed, but this was only assured as part of the audit process. As it is proposed that the reconciliation file will serve both the reference costs and PLICS elements of the national cost collection, activity reconciliation to HES will be part of the collection for all acute trusts for both the reference costs and PLICS.

60. All acute providers should reconcile their national cost collection activity for APC, OP and A&E to their final SUS submission, which is on or before 21 May 2018.¹¹

4: Role of NHS Digital

Background

61. NHS Digital provides a range of services used by healthcare professionals, research bodies, public sector organisations and commercial entities across England. NHS Digital is experienced in specifying, acquiring and processing national data collections.

62. For the national cost collection, NHS Improvement has requested that NHS Digital establishes and operates a system to collect reference costs and patient-level costing information. The patient-level request is made under Section 255 of the Health and Social Care Act 2012.

63. A further request from NHS Improvement to NHS Digital is planned in Q1 2018 to cover the increase in PLICS trusts planned for collection. Table 7 sets out the current expectation and is subject to that request being finalised.

Table 7: Role of NHS Digital in the reference cost and PLICS collections

<table>
<thead>
<tr>
<th>Area</th>
<th>NHS Digital’s responsibility</th>
<th>RC</th>
<th>PLICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection administration</td>
<td>The detail of the upload process is still being discussed with NHS Digital; the following paragraphs outline our current intentions. While the responsibility for the management of the collections (ie query resolution, workbook queries and contacting trusts to confirm submission dates) will sit with NHS Improvement, the issuing and maintenance of passwords and system access will be the responsibility of NHS Digital.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Conduct data quality and validation checks</td>
<td>While most of the data quality and validation checks will be carried out either in the workbook for reference costs or in the NHS Improvement data validation tool for PLICS, NHS Digital carries out some additional checks of the data.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Area</td>
<td>NHS Digital’s responsibility</td>
<td>RC</td>
<td>PLICS</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----</td>
<td>-------</td>
</tr>
<tr>
<td>Linking data with the HES dataset</td>
<td>NHS Digital will link PLICS to HES to reduce the size of the PLICS collection, and ensure one version of activity data is used in national datasets. This merged dataset is called the patient-level costing dataset (PLCDS).</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>PLICS upload</td>
<td>As with the early implementation programme this will be via SEFT. You will submit your data to NHS Digital and it will process, pseudonymise and share it with NHS Improvement for onward data processing and analysis.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Reference costs upload</td>
<td>The detail of the upload process is still being discussed with NHS Digital; the following paragraphs outline our current intentions.</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

NHS Digital will host the collection system but the responsibility for the management of the collection will remain with the reference costs collection team.

You will upload your entire workbook to SDCS; from there NHS Digital will take information from the output tab and feed it into a series of reports. Access to the reports will be via self-service and you will be able to see data for your own trust and at an aggregated national level only.

The collections team in NHS Improvement will be able to access the full dataset as it is submitted to be able to share with trusts the mid-collection validation outputs.

Confirmation of the above and full details of accessing and using SDCS will be issued in the workbook and system user guide, which will be released alongside the collection workbooks.
5: National cost collection guidance

Costing services for 2018

64. Table 8 indicates which sections of the guidance should be read by which service providers.

Table 8: Services collected by provider type

<table>
<thead>
<tr>
<th>Section</th>
<th>Contents</th>
<th>Acute</th>
<th>PLICS acute providers</th>
<th>Mental health</th>
<th>Community</th>
<th>Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2</td>
<td>Scope of activity and cost data to be collected in 2018</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>3</td>
<td>Regulatory requirements and standards</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>4</td>
<td>Role of NHS Digital</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>5</td>
<td>National cost collection guidance</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>6</td>
<td>Data quality and validation</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7</td>
<td>Specific PLICS acute guidance</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Admitted patient care</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Outpatient services</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Cancer multidisciplinary teams</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Accident and emergency</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Treatment function codes

65. Admitted patient care, outpatient, and some unbundled services should be reported by treatment function.\(^{12}\) In November 2012 the Information Standards Board (ISB) issued the latest changes to treatment function codes (TFCs) in Amd 17/2012.\(^{13}\) These changes have been incorporated into the list of TFCs\(^{14}\) in the Data Dictionary, but are only available to flow in the latest version of the commissioning datasets (CDS 6.2).\(^{15}\) These TFCs will be available in the

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\(^{12}\) [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)


\(^{15}\) [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)
reference costs workbook and PLICS specification files, except those listed in Table 9.

Table 9: TFCs excluded from the national cost collection files

<table>
<thead>
<tr>
<th>TFC</th>
<th>Description</th>
<th>Rationale for exclusion</th>
<th>Paragraph</th>
</tr>
</thead>
<tbody>
<tr>
<td>264</td>
<td>Paediatric cystic fibrosis</td>
<td>Costs and activity should be reported against cystic fibrosis year-of-care currencies</td>
<td>604</td>
</tr>
<tr>
<td>343</td>
<td>Adult cystic fibrosis service</td>
<td>Costs and activity should be reported against cystic fibrosis year-of-care currencies</td>
<td>604</td>
</tr>
<tr>
<td>424</td>
<td>Well babies</td>
<td>Costs should be reported under obstetrics (501) or midwife episodes (560), and activity excluded</td>
<td>123</td>
</tr>
<tr>
<td>700</td>
<td>Learning disability</td>
<td>Learning disability services are excluded from reference costs</td>
<td>611</td>
</tr>
</tbody>
</table>

Healthcare resource groups

66. 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, accident and emergency and unbundled services are collected using, HRG4+.

67. Providers must use outputs from the HRG4+ 2017/18 reference costs grouper, and the supporting documentation, when compiling their reference costs.

68. 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 accident and emergency. 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.

69. Unbundled HRGs (Section 12: Unbundled services) 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. Table 10 lists HRGs where zero costs should be allocated. We will exclude these HRGs from the workbooks.
### Table 10: Zero-cost HRGs

<table>
<thead>
<tr>
<th>HRG</th>
<th>Description</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>DZ13A</td>
<td>Cystic fibrosis with CC score 1+</td>
<td>Costs should be reported against cystic fibrosis year-of-care currencies</td>
</tr>
<tr>
<td>DZ13B</td>
<td>Cystic fibrosis with CC score 0</td>
<td></td>
</tr>
<tr>
<td>PD13A</td>
<td>Paediatric cystic fibrosis with CC score 5+</td>
<td></td>
</tr>
<tr>
<td>PD13B</td>
<td>Paediatric cystic fibrosis with CC score 2 to 4</td>
<td></td>
</tr>
<tr>
<td>PD13C</td>
<td>Paediatric cystic fibrosis with CC score 1</td>
<td></td>
</tr>
<tr>
<td>PD13D</td>
<td>Paediatric cystic fibrosis with CC score 0</td>
<td></td>
</tr>
<tr>
<td>LA97A</td>
<td>Same-day dialysis admission or attendance, 19 years and over</td>
<td>Costs should be reported against the LD HRGs</td>
</tr>
<tr>
<td>LA97B</td>
<td>Same-day dialysis admission or attendance, 18 years and under</td>
<td></td>
</tr>
<tr>
<td>PB03Z</td>
<td>Healthy baby</td>
<td>Costs should be reported as part of the maternity delivery episode</td>
</tr>
<tr>
<td>SB97Z</td>
<td>Chemotherapy core HRGs</td>
<td>Costs should be reported as the unbundled delivery code</td>
</tr>
<tr>
<td>SC97Z</td>
<td>Radiotherapy core HRG</td>
<td>Costs should be reported under the unbundled delivery code</td>
</tr>
<tr>
<td>RD97Z</td>
<td>Diagnostic imaging core HRG</td>
<td>Costs should be reported under the unbundled radiology HRG</td>
</tr>
<tr>
<td>RN97Z</td>
<td>Nuclear medicine core HRG</td>
<td>Costs should be reported under the unbundled HRG</td>
</tr>
</tbody>
</table>

70. 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 in HRG4+ and to other services in reference costs, except where specified, e.g. cystic fibrosis.
6: Data quality and validation

Background

71. Accurate cost data is fundamentally important to support the joint responsibility of NHS Improvement and NHS England for pricing NHS services in England.

72. The accuracy is also important for NHS providers and commissioners.

73. Over the years the range of uses of reference cost data at a national level has increased, Table 11 below shows some examples of the range of uses of the data and therefore the importance of submitting accurate data.

Table 11: National and local uses of reference costs data

<table>
<thead>
<tr>
<th>National uses for reference costs data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Academia and informing national policy</strong>: Reference costs data is widely used in academia for a range of studies into the cost of delivering healthcare in England. They are also used by the Department of Health and Social Care when considering the costs of implementing new policies regarding service delivery.</td>
</tr>
<tr>
<td><strong>Developing casemix</strong>: NHS Digital uses the reference costs data to analyse changes in healthcare delivery. With clinical and costing colleagues from across the NHS, it implements improvements to the currencies used in reference costs to better reflect the way in which care is delivered.</td>
</tr>
<tr>
<td><strong>The Getting It Right First Time (GiRFT) Programme</strong>: GiRFT is helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes.</td>
</tr>
<tr>
<td><strong>Parliamentary questions and freedom of information requests</strong>: Reference costs data is regularly required to answer parliamentary questions from members of both houses. The data is also used to respond to freedom of information requests from members of the public.</td>
</tr>
</tbody>
</table>
**National uses for reference costs data**

**Reconciliation of data to the PLICS collection**: Reference costs data has in the past been used to understand where there are variances between the two datasets. In the 2018 national cost collection, the reference costs data will reconcile to PLICS data for the first time in APC, OP and A&E, with a view to discontinuing reference costs in those areas in future years.

**Setting the national tariff**: Reference costs have historically been the primary source of data used to inform the national tariff.

**Weighted activity units (WAU)**: The dataset is being used by the Department of Health and Social Care and NHS Improvement to develop a productivity and efficiency measure, known as the WAU metric. This work was led by Lord Carter of Coles to help providers compare their relative efficiency performance, with the reference costs being the main dataset. It is important there is a nationally consistent apportionment of costs to codes to help providers identify where they have opportunities to drive productivity and efficiency improvements.

**Local uses of reference costs data**

**Maternity pathway costs**: In the 2017 cost collection we highlighted the problem of movements of patient income transactions being dealt with in the ledger. We included guidance to ensure income/cost were not part of the reference cost quantum. This will need to continue for the 2018 collection and must be taken into account in PLICS.

**National dataset reconciliation**: Reconciliation of submitted activity has always been a requirement of the reference costs collection. However, confirmation that this step has been done has only ever been via the checklist, then assured by the audit process. For the acute PLICS collection, the reconciliation is collected to give immediate assurance of the activity submitted. As the reconciliation is for both the reference costs and PLICS collections, we propose that the national dataset reconciliation is completed and submitted to NHS Improvement as part of the reconciliation workbook.

**Non-patient activity**: Income from non-patient activity has been allowable in the reference cost quantum to date, but the PLICS submission required costs of non-patient activities. Again, to align the two collections we would need to follow one methodology. We will continue to allow netting off income in reference costs in 2018 and this should also be applied to PLICS. To understand the costs for non-patient activity, we will collect the costs as a memorandum item only.
74. Reference costs also support the Department of Health and Social Care’s commitment to improving data transparency and making information available to the public.

75. All the data entered by providers into the submission files will be validated. For full details of the validations, see the guide to completing the submission document that will be released with the workbooks and PLICS file specifications.

76. Our mandatory validations (see Table 12) are designed to assure the basic integrity of the data submitted. All validations are embedded in the reference costs workbook and NHS Improvement’s data validation tool. Providers will not be able to sign off their returns until their data passes each of these validations.

77. Our non-mandatory validations (see Table 13) are designed to improve the quality and accuracy of the data.

78. Failing a non-mandatory validation is not in itself an indication that the data is incorrect. 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 providers to consider these validations and make any necessary revisions, confirming the extent to which they have done so on the self-assessment quality checklist in the reconciliation area of the collection workbook.

Table 12: List of mandatory validations for reference costs

<table>
<thead>
<tr>
<th>No.</th>
<th>Validation</th>
<th>Description</th>
<th>Worksheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Activity = integer</td>
<td>Activity must be an integer</td>
<td>All</td>
</tr>
<tr>
<td>2</td>
<td>Activity &gt; 0</td>
<td>Activity must be positive</td>
<td>All</td>
</tr>
<tr>
<td>3</td>
<td>Activity and unit cost</td>
<td>If activity is reported, then a unit cost must be reported, and vice versa</td>
<td>All</td>
</tr>
<tr>
<td>4</td>
<td>Bed days &gt;= FCEs</td>
<td>Number of inlier bed days must be greater than or equal to FCEs</td>
<td>IP</td>
</tr>
<tr>
<td>5</td>
<td>Duplicate entry</td>
<td>Each combination of department code, service code and currency code must be unique</td>
<td>All</td>
</tr>
<tr>
<td>No.</td>
<td>Validation</td>
<td>Description</td>
<td>Worksheet</td>
</tr>
<tr>
<td>-----</td>
<td>------------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>6</td>
<td>Excess bed-day costs without excess bed-day activity</td>
<td>If excess bed-day costs are reported, then excess bed-day activity must be reported, or vice versa</td>
<td>IP</td>
</tr>
<tr>
<td>7</td>
<td>Excess bed days without inlier activity</td>
<td>If excess bed-day costs are reported, inlier activity must be reported</td>
<td>IP</td>
</tr>
<tr>
<td>8</td>
<td>Inlier bed days $\leq$ HRG trim point * number of FCEs</td>
<td>Inlier bed days must be less than or equal to the HRG trim point multiplied by number of FCEs</td>
<td>IP</td>
</tr>
<tr>
<td>9</td>
<td>Invalid code</td>
<td>Department code (eg DC), service code (eg 100) or HRG code (eg AA22C) is invalid</td>
<td>Flexible&lt;sup&gt;16&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
| 10  | Memorandum information | The following memorandum information must be supplied in addition to unit cost and activity:  
- number of inlier bed days  
- number of adult critical care periods  
- average number of home haemodialysis sessions per week  
- number of direct access pathology tests  
- average cluster review period and number of completed cluster review periods  
- number of high intensity contacts  
- number of low intensity contacts  
- total number of cluster days  
- average length of episode  
- average number of contacts per episode  
- number of service users | IP, CC, RENAL, DAP, MHCC, MHCCIAPT, SECUREMH |
| 11  | Missing code | Missing department, service or currency code within a row of data | Flexible |
| 12  | Missing costs and activity | Codes have been supplied, but no unit costs or activity | Flexible |
| 13  | NEL LoS $\geq$ 2 | Average length of stay, $((\text{number of inlier bed days} + \text{excess bed days}) / \text{number of FCEs})$, must be greater than or equal to 2 for non-elective long stays | IP |
| 14  | Quantum | The sum of unit costs multiplied by activity must be within +/- 1% of the reconciliation statement | N/A |
| 15  | Unit cost = #.## | Unit cost must be to two decimal places | All |

<sup>16</sup> Flexible worksheets have not been pre-populated with data. Flexible worksheets should be populated with applicable department, service and currency code combinations.
<table>
<thead>
<tr>
<th>No.</th>
<th>Validation</th>
<th>Description</th>
<th>Worksheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Unit cost &gt;= 0.01</td>
<td>Unit cost must be positive and greater than or equal to £0.01</td>
<td>All worksheets except those listed in 17 and 18</td>
</tr>
<tr>
<td>17</td>
<td>Unit cost &gt;= 0.5</td>
<td>Unit cost must be positive and greater than or equal to £5.00</td>
<td>OPATT, OPPROC, CR, IMAG, HCD, REHAB, SPC</td>
</tr>
<tr>
<td>18</td>
<td>Unit cost &gt;= 20</td>
<td>Unit cost must be positive and greater than or equal to £20.00</td>
<td>DC, IP, CMDT</td>
</tr>
</tbody>
</table>

**Table 13: List of non-mandatory validations for reference costs**

<table>
<thead>
<tr>
<th>No.</th>
<th>Validation</th>
<th>Work sheets</th>
<th>Materiality threshold</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Day-case unit cost is more than double the ordinary elective unit cost for the same HRG and the same TFC</td>
<td>DC, IP</td>
<td>More than 10 day-case FCEs and more than 10 ordinary elective FCEs</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>Follow-up unit cost is more than double the first unit cost for the same outpatient attendance in the same TFC</td>
<td>OPATT</td>
<td>More than 10 follow-ups and more than 10 firsts</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td>Non-consultant led unit cost is more than double the consultant-led unit costs for the same outpatient attendance in the same TFC</td>
<td>OPATT</td>
<td>More than 10 non-consultant led and more than 10 consultant-led</td>
<td>None</td>
</tr>
<tr>
<td>4</td>
<td>Outliers: unit cost is less than one 10th or more than 10 times the national mean unit cost. The workbooks will use 2016/17 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.</td>
<td>All</td>
<td>More than 10 activities</td>
<td>None</td>
</tr>
<tr>
<td>5</td>
<td>Paediatric critical care HRGs are being reported by the expected organisations in Table 22 and Table 23 only</td>
<td>CC</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>No.</td>
<td>Validation</td>
<td>Work sheets</td>
<td>Materiality threshold</td>
<td>Exceptions</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Single professional unit cost is more than double the multiprofessional unit cost for the same outpatient attendance in the same TFC.</td>
<td>OPATT</td>
<td>More than 10 single and more than 10 multi</td>
<td>None</td>
</tr>
<tr>
<td>7</td>
<td>Unit cost over £50,000</td>
<td>All</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>8</td>
<td>Unit cost under £5</td>
<td>All</td>
<td>None</td>
<td>These services are excluded:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• ambulance service calls</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• direct access pathology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• mental healthcare clusters</td>
</tr>
<tr>
<td>9</td>
<td>Variance between 2016/17 and 2017/18 total costs or total activity is greater than 25%. The workbook analysis will be at worksheet level. The mid-collection feedback will be by department and HRG subchapter for acute services, and department, service and currency for non-acute services</td>
<td>All</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>10</td>
<td>Different A&amp;E department type reported in reference costs than in the NHS national statistics for quarterly A&amp;E activity.</td>
<td>EM</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**PLICS: Additional validations**

79. For trusts carrying out the PLICS collection there are two additional validations in the reference costs workbook.

80. These will check for variances between the reference costs data and the PLICS data in all areas where data has been submitted in both collections.

81. Table 14 shows the proposed tolerances allowable for the validations and their status.
82. We will not be able to confirm these tolerances until we have carried out testing with trusts. We are planning to carry out the testing in February and will share final detail on these validations in the workbook user guide.

### Table 14: Proposed additional validations for trusts submitting PLICS data

<table>
<thead>
<tr>
<th>No.</th>
<th>Proposed validation</th>
<th>Description</th>
<th>Proposed status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total costs and activity to reconcile at department level</td>
<td>The total costs and activity for reference costs and PLICS should reconcile to within 1% at department level. The workbook will take account of areas of the reference costs collection that are out of scope in PLICS (eg HIV) before performing the validation.</td>
<td>Mandatory</td>
</tr>
<tr>
<td>2</td>
<td>Total costs and activity to reconcile at department/service/currency level</td>
<td>The total costs and activity for reference costs and PLICS should reconcile to within 5% at a department/service/currency level.</td>
<td>Non-mandatory</td>
</tr>
</tbody>
</table>

83. As well as the validations for PLICS listed above, several other validations are carried out on PLICS data in the data validation tool.

84. A list of the validations will be available on NHS Improvement's 2017/18 PLICS cost collection webpage. This URL is not yet available but will be publicised before the collection.
7: Specific PLICS acute guidance

Background

85. This section provides an overview of the patient-level information and costing systems (PLICS) collection in summer 2018. Specific treatment and reporting of costs and activities for PLICS is outlined at the end of the sections below.

86. Table 8 (in Section 5: National cost collection guidance) outlines all the sections that apply to the PLICS submission. Where the treatment of costs or activity differs between PLICS and the main reference costs submission, this will be outlined at the end of each chapter under the subsection ‘Treatment for PLICS’.

87. The 2018 national cost collection begins the transition to a single cost collection. Aligning PLICS and reference costs collections this year should realise these benefits:

- less burden, reducing the need to make material changes to models to generate PLICS or reference costs
- greater insight into the cost data, as there will be a better understanding of the relationship between collection resources and activities
- one consistent version of service cost and activity will be used across the NHS.

Collection outputs

88. Activity datasets that should be reported at patient level for this collection are:

- admitted patient care (APC) finished consultant episodes (FCEs), including regular day and night attenders
- non-admitted patient care (NAPC) attendances, also known as outpatients (OP), including ward attenders
- accident and emergency attendances.
89. The collection fields will be listed in the collection specification files which will be released in March.

**Collection resources and activities**

90. Provider costs have been classified into resources to identify the staff types and materials used to treat patients. The activities outline what treatment or investigations the patient received.\(^{17}\)

91. Following consultation with providers, NHS Digital and users of PLICS data, the resources have been reduced this year to help reduce file sizes, cost mapping, improve processing and provide the information required by end-users. Most of the ‘department costs’ resources have been removed, with one remaining for the reporting of therapies, pharmacy, pathology and diagnostics testing. Equipment and consumables for all other services are grouped into the ‘supplies and services’ resource, and there is one ‘support cost’ resource this year.

92. Table 15 indicates the suggested combinations of resources and activities in the collection. This year there may be validations that restrict the possible combinations of resources and activities, to improve the comparability of costs.

93. The collection resources and activities are an aggregation of allocation resources and activities in the costing standards. Please see the technical guidance in the costing standards for the detailed mapping from allocation resource and activities to the collection codes.

**Table 15: Activities and resources for the PLICS collection**

For Table 15, please see tab CC.4 of the technical document that is published as part of the acute *Healthcare costing standards for England*\(^{18}\)

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\(^{17}\) For further information see Spreadsheets CC.2 and CC.3 in the costing standards technical document. [https://improvement.nhs.uk/resources/approved-costing-guidance-standards](https://improvement.nhs.uk/resources/approved-costing-guidance-standards)

\(^{18}\) [https://improvement.nhs.uk/resources/approved-costing-guidance-standards/#h2-healthcare-costing-standards-for-england](https://improvement.nhs.uk/resources/approved-costing-guidance-standards/#h2-healthcare-costing-standards-for-england)
Information governance – how the patient-level costing (acute) dataset (PLCADS) will be used

Information governance

94. The patient-level costing (acute) dataset (PLCADS) contains unit costs for inpatient admissions, accident and emergency, and outpatient attendances for NHS providers in England.

95. NHS Digital will collect the PLCADS information from providers (subject to a mandatory request from NHS Improvement being accepted by NHS Digital). The expectation is that NHS Digital may publish and/or disseminate data collected and/or created under that request, which may include dissemination to other organisations. The acceptance of the mandatory request and any subsequent use of PLCADS data collected under that mandatory request would be subject to the appropriate information governance processes and approval.

96. If you have any objections with how your data will be used, please contact costing@improvement.nhs.uk.

How NHS Improvement will use PLCADS

97. HES-PLCADS is created by NHS Digital at NHS Improvement’s request. NHS Digital collects PLCADS data from NHS providers, matches this dataset with the Hospital Episode Statistics (HES), adds key identifiers (to allow NHS Improvement to subsequently link this data with HES) and pseudonymises the data before HES-PLCADS is provided to NHS Improvement.

98. We intend to use the HES-PLCADS data in connection with any of our pricing or other functions:¹⁹

- informing the national tariff
- producing and distributing patient-level data in our tools for NHS providers, eg national PLICS portal and PLICS data quality tool²⁰

¹⁹See Section 70 of the Health and Social Care Act 2012.
²⁰https://improvement.nhs.uk/resources/tools-for-using-costing-data/
• supporting efficiency and quality of care improvement programmes, eg Getting It Right First Time (GIRFT)\textsuperscript{21} and operational productivity in NHS providers
• informing and modelling new methods of pricing NHS services
• informing new approaches and other changes to currency design
• improving future cost collections
• informing the relationship between provider and patient characteristics and cost
• developing analytical tools and reports to help providers improve their data quality, identify operational and clinical efficiencies, and review and challenge their patient-level cost data.

99. As well as sharing the HES-PLCADS data within NHS Improvement, we intend (subject to NHS Digital’s approval) to share pseudonymised HES-PLCADS patient-level data with participating trusts and arm’s length bodies using our tools and reports.

100. The benefits of sharing the pseudonymised HES-PLCADS patient-level data include:

• across providers, it supports the implementation of accountable care systems and organisations and the additional functionality in new releases of our tools
• with the Department of Health and Social Care, NHS England, NHS Digital and other organisations and individuals, it helps to:
  – identify operational and clinical efficiencies, eg NHS RightCare\textsuperscript{22}
  – provide comparative costs to support evaluation of new or innovative medical technologies
  – respond to freedom of information requests and parliamentary questions
  – benchmark performance against other NHS and international providers
  – inform academic research.

\textsuperscript{21} \url{http://gettingitrightfirsttime.co.uk/}
\textsuperscript{22} \url{www.england.nhs.uk/rightcare/what-is-nhs-rightcare/}
Services excluded from PLICS but reported in the reference costs workbook

101. The PLICS collection is currently underpinned by HES, and reports costs for hospital episodes, outpatient and emergency attendances. To reconcile PLICS to reference costs, the scope of the two collections was amended. Table 16 below lists all the services that are excluded from the PLICS extract files, but costs and activity must be reported in the reference costs workbook in accordance with the rest of this guidance.

102. If you have any queries on the scope of the PLICS collection, please contact costing@improvement.nhs.uk.

Table 16: Services excluded from the acute PLICS collection but which are to be reported in the reference costs workbook

<table>
<thead>
<tr>
<th>Section</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>8: Admitted patient care</td>
<td><strong>Admitted patient care</strong></td>
</tr>
<tr>
<td></td>
<td>• Reproductive medicine</td>
</tr>
<tr>
<td></td>
<td>• Gender reassignment</td>
</tr>
<tr>
<td></td>
<td>• Excess bed days (costs should be fully absorbed in the core episode)</td>
</tr>
<tr>
<td>9: Outpatient services</td>
<td><strong>Outpatient services</strong></td>
</tr>
<tr>
<td></td>
<td>• Reproductive medicine</td>
</tr>
<tr>
<td></td>
<td>• Gender reassignment</td>
</tr>
<tr>
<td></td>
<td>• HIV</td>
</tr>
<tr>
<td></td>
<td>• Family planning clinic</td>
</tr>
<tr>
<td>10: Cancer multidisciplinary teams</td>
<td><strong>Cancer multidisciplinary teams</strong></td>
</tr>
<tr>
<td>12: Unbundled services</td>
<td><strong>Unbundled services</strong></td>
</tr>
<tr>
<td></td>
<td>• Chemotherapy</td>
</tr>
<tr>
<td></td>
<td>• Critical care</td>
</tr>
<tr>
<td></td>
<td>• Radiotherapy</td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>• Specialist palliative care</td>
</tr>
<tr>
<td>Section</td>
<td>Contents</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>13: Renal dialysis</td>
<td>Renal dialysis</td>
</tr>
</tbody>
</table>
| 14: Direct access services | Direct access services  
| | • Pathology services  
| | • Diagnostic services |
| 15: Mental health services | ALL Mental health services |
| 16: Community services | ALL Community services |
| 17: Ambulance services | Ambulance services |
| 18: Cystic fibrosis | Cystic fibrosis |
| 19: Services excluded from the national cost collection | Services excluded from the cost collection |
8: Admitted patient care

Classification of admitted patient care

103. This section covers the following types of admitted patient care (APC):

- day-case electives\(^\text{23}\)
- ordinary electives\(^\text{24,25}\)
- ordinary non-electives\(^\text{26}\)
- regular day or night admissions.\(^\text{27}\)

104. Providers must submit their APC costs by consultant episode (FCE), treatment function code (TFC) and healthcare resource group (HRG). There will be additional fields collected for PLICS; please see PLICS file specifications, which will be released in March 2018.

105. The HRG4+ 2017/18 reference costs grouper will attach a core HRG to every FCE. Providers will only report core HRGs in APC. Providers will report the costs of unbundled HRGs separately, as described in Section 7: Specific PLICS acute guidance, with the exception of unbundled diagnostic imaging HRGs, the costs of which will be included with the core HRGs in APC.

Costing consultant episodes

106. To ensure the reference costs collection and the PLICS collection align, all episodes completed in the collection year must be costed and reported. This includes episodes that started in the previous collection year but finished in-year, and episodes that started and finished in the collection year. Figure 1 below outlines the different types of episodes included in this collection.

---


\(^{26}\) All national codes excluding 11, 12 and 13 at

107. The matching rules and auxiliary activity data may have to be adjusted to include data from previous years so episodes which span two or more years can be costed. Cost should not be brought forward from previous collection years; the total APC costs for the collection year should be allocated across all episodes that end in the year regardless of when they started.

**Figure 1: Reporting of episodes**

- **Type of episode**
  - Over start period
  - Over end period
  - In period
  - Ongoing throughout period

<table>
<thead>
<tr>
<th>Type of episode</th>
<th>31-Mar</th>
<th>01-Apr</th>
<th>31-Mar</th>
<th>01-Apr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over start period</td>
<td>IN</td>
<td></td>
<td>IN</td>
<td></td>
</tr>
<tr>
<td>Over end period</td>
<td></td>
<td>OUT*</td>
<td></td>
<td>OUT*</td>
</tr>
<tr>
<td>In period</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing throughout period</td>
<td></td>
<td>OUT*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Patients not discharged at collection year end

**Finished consultant episode costs**

108. The following paragraphs cover issues that affect the collection of FCE costs.

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

109. 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.

110. All ordinary non-elective activity must therefore be separately identified as long or short stay by:

- completing the input fields required by the grouper for critical care, rehabilitation and specialist palliative care length of stays
- processing the data through the grouper, which deducts these stays from the core stays
- classifying the data, after these length of stay adjustments, as either:
  - **long stay**: length of stay (number of inlier plus excess bed days divided by number of FCEs) equal to two or more days; or
- **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.

**Incomplete consultant episodes (memorandum item)**

111. In future collections we intend to move to collecting costs and activity for complete and incomplete episodes. Before moving to this approach, we need to understand how material incomplete episodes are and how they may fluctuate each year.

112. For the 2018 national cost collection, we are asking for a memorandum item to capture the estimated costs and activity for incomplete episodes at the end of the 2017 collection year and at the end of the 2018 collection year.

113. As this is the first year of collecting and costing incomplete episodes, we encourage providers to use their costing systems where possible to match the existing costs, and estimate the incomplete part using judgement and knowledge of the HRG assigned.

114. This must not impact on the costing of your reference costs finished consultant episodes.

**Excess bed days and trim points**

115. For the reference costs collection, excess bed-day costs must be reported separately for ordinary elective and ordinary non-elective FCEs.

116. The cost per day for excess bed days must include only costs associated with the ward stay, eg nursing, medical staff ward rounds, consumables, food and linen. Other relevant treatment costs such as blood tests, drugs, dressings and therapies are also included. Operating theatre costs, chemotherapy costs, specialist procedure suites, treatment rooms (eg plaster rooms) and unbundled costs (outlined in Section 12: Unbundled services) must be excluded from the excess bed-day costs.
117. 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 the truncated bed days,\textsuperscript{28} although we recognise that active treatment does sometimes continue beyond the trim point – especially for specialised services.

118. Providers should use the trim points included in the HRG4+ 2017/18 reference costs grouper and supporting documentation to calculate HRG length of stay and associated excess bed days.

119. 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**

120. Regular day or night admissions\textsuperscript{29} are reported in the FCE collection. Admissions for specialist care such as cystic fibrosis, chemotherapy, radiotherapy or renal dialysis should be reported against the relevant sections of the collection, and not under regular day or night admissions.

**Obstetrics and maternity admitted patient episodes**

121. Pathway costs for maternity are not being collected for 2018. NHS England is keen to understand pathway costs to inform the national tariff. Therefore, and to assist costing pathway activity, the standards team developed a costing approach, *Standard CA8: Maternity*.\textsuperscript{30} Emphasis lies on the collection of the patients’ pathway level from their booking appointment. To collect this data for reference costs, work would be needed on the HRGs or this data would have to be separated from the IP/DC/OP files, which would make aligning PLICS and reference costs difficult and add burden on the sector.

\textsuperscript{28} Truncated bed days are days that occur within the trim point for an HRG.

\textsuperscript{29} \url{www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1}

\textsuperscript{30} See the acute costing approaches standards: \url{https://improvement.nhs.uk/resources/approved-costing-guidance-standards}
122. 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, as non-elective.

123. All activity relating to HRG PB03Z (healthy baby) or TFC 424 (well babies) should be excluded. Associated costs should be reported as part of the total costs of the maternity delivery episode against the relevant HRG. Note that the Data Dictionary defines TFC 424 as ‘care given by the mother or substitute with medical and neonatal nursing advice if needed’. TFCs describe the carer, in this case the mother or substitute. We would expect providers to use the TFC of the appropriate healthcare professional (obstetrician, paediatrician or consultant midwife) rather than TFC 424 for babies with a minor or major diagnosis (HRGs PB04Z – PB06Z) 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 a support cost to the relevant service.

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

125. The grouper includes HRGs that cover antenatal and postnatal 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.

126. 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.

127. Maternity outpatients, scans, screens and tests are covered in paragraph 177. Community midwifery is covered in paragraph 517.

31 www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1
Renal transplantation

128. The costing approach Standard CA4: Renal transplant\(^\text{32}\) contains guidance on costing renal transplantation.

129. Please take extra care to follow the guidance on drugs that appear on the high cost drug list (see worksheet 13b in Annex A of the national tariff\(^\text{33}\)). Any drug on the list must not be added back to the renal activity for reference costs but should be identified as a high cost drug to ensure the PLICS submission and the reference cost submission are reconcilable.

Gender reassignment

130. Reproductive medicine and gender reassignment are services where legal restrictions apply, preventing the flow of patient identifiable data to NHS Digital.

131. To enable the inpatient and day-case worksheets for reference costs to reconcile to the PLICS data, we ask all providers to submit any gender reassignment costs as a memorandum item in the reconciliation worksheets for reference costs. More detail will be provided in the workbook documentation.

132. Gender reassignment is identified by OPCS codes, not HRGs, making them difficult to identify after the collection process. Table 17 below outlines the codes to identify gender reassignment procedures and therefore the patients.

**Table 17: Gender reassignment OPCS codes**

<table>
<thead>
<tr>
<th>Category</th>
<th>Code-to-group type</th>
<th>Code type</th>
<th>Code</th>
<th>Code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender reassignment</td>
<td>Core1</td>
<td>OPCS</td>
<td>X151</td>
<td>Combined operations for transformation from male to female</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>Core1</td>
<td>OPCS</td>
<td>X152</td>
<td>Combined operations for transformation from female to male</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>Core1</td>
<td>OPCS</td>
<td>X154</td>
<td>Construction of scrotum</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>Core1</td>
<td>OPCS</td>
<td>X158</td>
<td>Other specified operations for sexual transformation</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>Core1</td>
<td>OPCS</td>
<td>X159</td>
<td>Unspecified operations for sexual transformation</td>
</tr>
</tbody>
</table>

\(^{32}\) [https://improvement.nhs.uk/resources/approved-costing-guidance-standards](https://improvement.nhs.uk/resources/approved-costing-guidance-standards)  
\(^{33}\) [https://improvement.nhs.uk/resources/national-tariff-1719/](https://improvement.nhs.uk/resources/national-tariff-1719/)
PLICS: Treatment for admitted patient care

133. Providers must submit their APC patient-level extracts for PLICS using the guidance above in Section 8: Admitted patient care, with the exception of excess bed days. For PLICS, the total episode costs should be reported in the patient-level extract.

134. High cost drugs are unbundled for reference costs submissions, but for PLICS high cost drugs must be reported using the appropriate collection activity at a patient level in the APC extract. The value for high cost drugs for APC will be reconciled to the reference cost spreadsheet as part of the collection pre-submission checks in the NHS Improvement data validation tool.

135. Reproductive medicine episodes (MC* HRGs) and gender reassignment episodes are excluded from the PLICS collection. Please use Table 17 and Table 18 to identify the episodes and costs to be removed from your PLICS collection. These services should be reported in reference costs only, in accordance with the guidance above.

Table 18: Reproductive medicine HRG codes

<table>
<thead>
<tr>
<th>Category</th>
<th>Exclusive to category</th>
<th>HRG</th>
<th>HRG description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC07Z</td>
<td>Intrauterine insemination with superovulation</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC08Z</td>
<td>Intrauterine insemination with superovulation, with donor</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC09Z</td>
<td>Intrauterine insemination without superovulation</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC10Z</td>
<td>Intrauterine insemination without superovulation, with donor</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC11Z</td>
<td>Implantation of embryo</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC12Z</td>
<td>Oocyte recovery</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC13Z</td>
<td>Donor oocyte recovery</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC14Z</td>
<td>Oocyte recovery with intracytoplasmic sperm injection</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC15Z</td>
<td>Oocyte recovery with pre-implantation genetic diagnosis</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC20Z</td>
<td>Surgical extraction of sperm</td>
</tr>
<tr>
<td>IVF</td>
<td>Yes</td>
<td>MC21Z</td>
<td>Collection of sperm</td>
</tr>
</tbody>
</table>
136. Memorandum items in Section 8: Admitted patient care are reported in the reference costs workbook only.
9: Outpatient services

Introduction

137. This section covers:

- outpatient attendances, including ward attendances
- procedure-driven HRGs in outpatients.

138. 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 in this section. Unbundled HRGs should be reported separately (Section 12: Unbundled services).

139. You should also refer to Standard CM3: Non-admitted patient care in the standards for acute costing methods.³⁴

Outpatient attendances

140. Outpatient attendances³⁵ in HRG4+ (WF01* and WF02*), generated from a number of mandated fields in the outpatient CDS, are organised by:

- first and follow-up attendance
- face-to-face and non face-to-face attendance
- single and multiprofessional attendance
- advice and guidance.

141. Where a patient sees a healthcare professional in an outpatient clinic 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.

³⁴ https://improvement.nhs.uk/resources/approved-costing-guidance-standards
³⁵ www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/o/out-patient_attendance_consultant_de.asp?shownav=1
142. Outpatient clinics held by a clinician or nurse while 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.

143. Reference costs do not distinguish between attendances that are pre-booked and those that are not. A patient being seen by a consultant other than the one they were admitted under (eg for psychiatric assessment of a medical patient), should be reported here as a consultant-led outpatient attendance (see paragraph 165 for a definition of what constitutes a consultant-led 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.36 No designated worksheet exists for ward attendances; costs and activity should be reported here as non-consultant led outpatient attendances under the appropriate TFC.

First and follow-up attendances

144. First attendances are defined in the Data Dictionary.37 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

145. Only non face-to-face contacts38 that directly support diagnosis and care planning and replace a face-to-face contact should be included in the collection. Telephone contacts and text messages solely for informing patient of results are excluded.

146. 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

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36 www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/w/ward_attendance_de.asp?shownav=1
37 www.datadictionary.nhs.uk/data_dictionary/attributes/l/first_attendance_de.asp?shownav=1?query=%%22first+attendance%%22&rank=100&shownav=1
38 www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1
young child. Contacts with proxies only count if the contact is instead 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, eg an infant or a person with a learning disability.

147. 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 exception of cancer multidisciplinary teams (as discussed in Section 10: Cancer multidisciplinary teams) and advice and guidance conversations with GPs. Where providers 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.

148. As a general principle, the same patient can access a service as face-to-face and non face-to-face contacts 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 stipulating that only those patients that have had a face-to-face contact can be counted as having subsequent non face-to-face contacts.

Advice and guidance on non face-to-face activity

149. As set out in the NHS operational planning and contracting guidance 2017-2019, and linked to the advice and guidance on CQUIN, local systems are being encouraged to introduce advice and guidance services as part of plans to manage demand in secondary care acute services.

150. To support this work we are introducing a collection of activity and costs related to advice and guidance services, based on CQUIN guidance.

151. The CQUIN scheme requires providers to set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice before referring patients to secondary care.

152. Advice and guidance (in the context of CQUIN), can be defined as non face-to-face activity which could be real-time/synchronous advice, such as a telephone

call, or asynchronous advice when carried out electronically through the NHS e-Referral Service (e-RS) or dedicated email addresses. It supports GPs in managing non-urgent (elective) patients whom they may be considering referring to secondary care. The types of advice that may be requested include, but are not limited to, treatment plans, interpretation of results and/or advice on appropriateness of referrals/tests.

153. The advice and guidance service should be consultant-led and delivered either by the consultant or by another senior clinician (including specialist registrars) where the consultant retains responsibility for the service and the advice provided.

154. The CQUIN scheme stipulates that providers should ensure IT systems can deliver the requirements of advice and guidance including the data capture needed for demonstrating benefits and tracking/charging activity.

155. During the consultation, we received responses from some providers indicating that identification and costing of this activity is possible.

156. If advice and guidance are being monitored for CQUIN payments, your commissioning team may have activity data and understand which specialties are receiving referrals from GPs.

157. As the request for advice and guidance has to come via a referral process, the booking team may know about this activity and how it is identifiable within your trust.

158. For the 2018 national cost collection we ask that this activity and cost information are collected as a memorandum item where possible. We wish to collect information at treatment function code level in relation to the number of requests received, responses made and the average cost per response. There is no change to the outpatient spreadsheet for advice and guidance. If your advice and guidance activity forms part of your outpatient non face-to-face activity, that is absolutely fine – continue to report against outpatient non face-to-face activity.
Single and multiprofessional

159. Multiprofessional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time.

160. Multidisciplinary 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 main specialties.

161. 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 multiprofessional or multidisciplinary attendances must be shown in the clinical notes or other documentation.

162. They do not apply if one professional is simply supporting another, clinically or otherwise, eg by taking notes, acting as a chaperone, undergoing training, undertaking professional update, operating equipment or 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.  

163. The multidisciplinary attendance definition does not apply to multidisciplinary meetings, where care professionals meet in the absence of the patient. Multidisciplinary meetings should not be recorded as multidisciplinary attendances.

Consultant-led and non-consultant led

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

www.datadictionary.nhs.uk/data_dictionary/attributes//joint_consultant_clinic_flag_de.asp?shownav=1?query=%22consultant+clinics%22&rank=85.71429&shownav=1
165. Consultant-led 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 in accordance with the mandatory outpatient attendance CDS type 020, using the consultant code field, main specialty code and TFC.

166. Clinics run by GPs 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.

167. Non-consultant led activity takes place in a clinic where the consultant is not in overall charge (ie any activity not covered in paragraph 165). 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.

Gender reassignment

168. To align PLICS and reference cost data and enable reconciliation between the two datasets, gender reassignment outpatient procedures will be collected on the memorandum list within the collection workbook. First and follow-up attendances for gender reassignment must be recorded on the outpatient sheet, as they cannot be identified in PLICS or reference costs.

169. Table 17 (above) outlines the codes that identify the outpatient procedure activity and costs that should be reported in the outpatient procedure sheet, as part of the relevant HRGs and in the memorandum worksheet.

170. We will release further guidance with the collection workbooks.

Audiology

171. Record audiology assessments as procedures in outpatients, using the HRG currencies described in paragraph 492.

41 www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_led_activity_de.asp?shownav=1
42 www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6-2/data_sets/cds_v6-2_type_020__outpatient_cds_fr.asp?shownav=1
43 www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultant_code_de.asp?shownav=1
HIV and AIDS

172. Nationally specified currencies for HIV adult outpatient services were introduced for contracting in 2013/14. The full mandated guidance for treatment of these currencies is available on the GOV.UK website. The currencies are a clinically designed year-of-care pathway for three categories of HIV adult patients (19 years and over). To support the currencies, the HIV and AIDS reporting system (HARS) has been introduced by Public Health England. All providers providing the HIV outpatient pathways must submit data to HARS. The dataset will support commissioning and epidemiology of HIV adult outpatient activity.

173. We are not collecting pathway costs for the HIV adult outpatient services in 2018. However, we are collecting the unit cost of attendances for patients with HIV or AIDS against these three categories:

- **Category 1 (new patients)** are newly diagnosed or have newly started on antiretroviral therapy (ARV drugs). These patients require more intensive clinical input than Category 2 (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 multidisciplinary teams.

- **Category 2 (stable patients)** covers patients who do not have one of the listed Category 3 complexities and are either not on ARV drugs or started ARV drugs more than one year ago. This category covers most patients and therefore should be used as the default category unless category 1 or 3 criteria can be demonstrated and validated.

- **Category 3 (complex patients)** covers patients who need high levels of maintenance. Complexities are:
  - current tuberculosis co-infection on anti-tuberculosis treatment
  - treatment for chronic viral liver disease
  - oncological treatment
  - active AIDS diagnosis requiring active management in addition to ARV drugs (not inpatient care)
  - HIV-related advanced end-organ disease

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45 www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVAndAIDSReportingSystem/
– persistent viraemia on treatment (more than six months on ARV drugs)
– mental illness under active consultant psychiatric care
– HIV during current pregnancy.

174. 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 297), and only the associated costs should be included.

175. The costs of HIV testing and partner notification are part of sexual health and should be reported under sexual health services (paragraph 178).

176. Some providers may not have the categories available locally. The attendance data by category can be requested via HARS directly from Public Health England. Please use the data request form.46

**Maternity outpatients and scans, screens and tests**

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

178. 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).

179. 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. This may result in a procedure-driven HRG.

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180. 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.

181. 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 Down's syndrome, specialist diagnostic laboratories, etc) should not be included in the obstetrics or maternity reference costs.

182. During the 2016 collection, the collection team received queries about the treatment of pathway payments made to providers that had seen a patient though they were not the trust at which the patient had chosen to give birth. The trust would not therefore have received the payment for their antenatal care. The payments (costs) and income for this type of activity are often monitored in the accounting ledger, rather than the patient income monitoring system. Therefore there can be large net gains/losses from organisations invoicing other trusts for pathway payment reimbursements. This scenario is shown in Figure 2.

**Figure 2: Costing maternity services**

<table>
<thead>
<tr>
<th>Patient A</th>
<th>Patient B</th>
</tr>
</thead>
<tbody>
<tr>
<td>has a scan at Trust B</td>
<td>has a scan at Trust A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust A</th>
<th>Trust B</th>
</tr>
</thead>
<tbody>
<tr>
<td>£ Pathway Payment for Antenatal Care</td>
<td>£ Pathway Payment for Antenatal Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust A invoices Trust B</th>
<th>Trust B invoices Trust A</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>-60</td>
</tr>
<tr>
<td>-80</td>
<td>80</td>
</tr>
</tbody>
</table>

The Ledger:

<table>
<thead>
<tr>
<th>Trust A</th>
<th>Trust B</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>-60</td>
</tr>
<tr>
<td>-80</td>
<td>80</td>
</tr>
</tbody>
</table>

-20 20

Trust A is making a **surplus** on maternity trading income, lowering costs of the maternity service.

Trust B is making a **loss** on maternity trading income, increasing costs of the maternity service.
183. To avoid double-counting activity or costs, we propose that both the income (invoices sent to providers only recorded in the ledger) and expenditure (payments made to providers that appear in the ledger) are removed from the reference cost quantum.

184. Providers should only submit activity and costs for the patients they have seen at their organisation, whether or not they have received the pathway payment for the patient.

185. There are lines in the reconciliation statement to add back the income and remove the expenditure that is in the ledger from the quantum of costs.

**Paediatric treatment function codes**

186. Providers should allocate costs and activity to paediatric TFCs in line with their Data Dictionary definition: “dedicated services to children with appropriate facilities and support staff”. A small number of patients aged 19 years and over also receive care in specialist children’s services, including patients with learning disabilities. Such activity is assumed to use similar resources to children rather than adults, and should also be reported under the relevant paediatric TFC.

**Sexual and reproductive health services**

187. Activity that takes place in a sexual and reproductive health clinic is defined by code FPC. It includes the costs of HIV testing and partner notification (paragraph 197).

**Therapy services**

188. 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

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different specialty, the costs will form part of the composite costs of that episode or attendance.

Procedures in outpatients

189. Providers 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.

PLICS: Treatment for outpatient services

190. Outpatient attendances and procedures should be reported by HRG and TFC currencies for PLICS. Unbundled service costs should be reported separately (Section 12: Unbundled services) except for diagnostic imaging and high cost drugs.

191. All diagnostic imaging costs, which are unbundled from outpatients in reference costs, are to be included in PLICS at patient level, but reported using the diagnostic imaging collection activities.

192. The NHS Improvement data validation tool will compare the costs for diagnostic imaging between PLICS and reference costs outpatient unbundled imaging HRGs to see if these values reconcile.

193. High cost drugs are unbundled for outpatients in reference costs but, for PLICS, high cost drugs must be reported using the appropriate collection activities at a patient level in the OP extract.

194. The value of high cost drugs in OP will be reconciled to the reference cost spreadsheet as part of the collection pre-submission checks in the NHS Improvement data validation tool.

195. HIV and AIDS outpatient activity is out of scope for PLICS. The cost and activity should be identified and removed from the outpatient quantum, and reported in the reference costs outpatient worksheet only.

196. Reproductive medicine and gender reassignment outpatient procedures are out of scope for PLICS. The cost and activity should be identified and removed from the outpatient quantum, and reported in the reference costs workbook only. Please use the codes listed in Table 17 and Table 18 to identify
the outpatient procedures activity and costs to remove from the outpatient quantum. First and follow-up attendances for reproductive medicine and gender reassignment are still in scope and should be reported in the PLICS outpatient file, as they cannot be identified in PLICS.

197. Activity that takes place in a sexual and reproductive health clinic\(^\text{48}\) is defined by code FPC in reference costs and may not be identifiable in PLICS data. The costs for sexual and reproductive health clinics are out of scope for PLICS 2018. This must be reported in the reference costs workbook only.

198. Memorandum items in Section 9: Outpatient services above are reported in the reference costs workbook only.

\(^{48}\) <https://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/s/sexual_and_reproductive_health_clinic_de.asp?shownav=1>
10: Cancer multidisciplinary teams

Introduction

199. Cancer multidisciplinary teams (CMDTs) have been defined by the National Institute for Health and Clinical Excellence (NICE) as essential to the delivery of high quality cancer care.

200. Providers should submit data against six categories of CMDT:

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

201. The CMDT 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, eg on relapse. The core role of the CMDT is to resolve difficulties in diagnosis and staging and to agree a management plan. Further definitions of CMDTs can be found in NICE improving outcomes guidance.\(^\text{49}\)

202. CMDT meetings take place in addition to and not instead of outpatient activity. Cancer outpatient clinics are often multidisciplinary and, similarly, CMDTs can deal specifically with one type of cancer or a group of cancers.

\(^{49}\)www.evidence.nhs.uk/search?q=improving+outcomes+guidance
203. We are aware that this service may have changed since its inception and CMDTs may not discuss outpatients exclusively; there may also now be an element of inpatient discussion. We will continue to collect activity and costs for all patients in 2018.

204. Providers should record all CMDT activity and not just outpatient activity.

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

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

207. Although a CMDT 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 support costs arising from the caseloads of other organisations.

208. You should also refer to the Standard CM9: Cancer MDT meetings costing method in the standards for acute costing methods.50

**PLICS: Treatment for CMDT**

209. CMDT costs must be unbundled for PLICS. These costs should not appear in the patient-level extract.

210. In the collection activity list, there is an ‘Other MDT’ activity to identify known costs associated to non-cancer MDTs. These costs must not be unbundled from OP or APC, but reported at a patient level using the other MDT activity.

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50 https://improvement.nhs.uk/resources/approved-costing-guidance-standards
11: Accident and emergency

211. NHS Digital is introducing a new emergency care dataset (EMCDS) for urgent and emergency care, replacing the current dataset used to collect information from emergency departments across England.

212. The new EMCDS will replace the current accident and emergency commissioning dataset (CDS type010) and will be implemented through a new version of the A&E CDS – CDS 6.2.1 Type 011 – ECDS.

213. This has been introduced to allow emergency department data to be comparable and complete for all attendance types.

214. The timescale for this is in two stages: Types 1 and 2 emergency departments to implement from October 2017, and Types 3 and 4 from October 2018.

215. Due to the change in mid-financial year, and because not all trusts will implement this straightaway, we will continue to collect the data as we have previously, using HRG4+. This will mean that trusts will have to map their data back to the old treatment codes for the grouper.

216. NHS Digital has released mapping guidance to help map back to the investigation and treatment codes for grouping purposes.\(^51\)

217. The remainder of this section covers all emergency medicine attendances at each of the four A&E department types, defined by the subchapter VB HRGs, supported by the A&E minimum dataset,\(^52\) and split between:

- patients who are admitted for further investigation or treatment rather than discharged from A&E
- patients who are not admitted but are discharged or die while in A&E.

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\(^{52}\) 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
218. Emergency departments (national code 01) and consultant-led mono-specialty accident and emergency services (02) may be 24-hour or non-24 hour.

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

220. ECDS streaming attendances should not be counted and costed.

221. Costs and activity for MIUs should only be reported separately if:

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

222. 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.

223. A&E mental health liaison services should be reported as set out in paragraph 459 and not under accident and emergency.

224. The costs of activity typically unbundled should be included in the core accident and emergency HRGs. The grouper will determine a single HRG for each A&E attendance record, irrespective of the presence of care elements unbundled from the core HRG when occurring in admitted patient or outpatient settings.

225. Patients brought in dead (A&E patient group code 70)\(^{53}\) should be coded and costed against HRG VB99Z – Patient Dead on Arrival.

**PLICS: Treatment for accident and emergency**

226. No specific treatment for PLICS; the above guidance applies to the PLICS A&E extracts.

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\(^{53}\) www.datadictionary.nhs.uk/data_dictionary/attributes/a/a_and_e_patient_group_de.asp?shownav=1
12: Unbundled services

Introduction to unbundled services

227. This section covers unbundled HRGs for:
   - chemotherapy
   - critical care
   - diagnostic imaging/nuclear medicine
   - high cost drugs and devices
   - radiotherapy
   - rehabilitation
   - specialist palliative care.

228. Unbundled HRGs for renal dialysis for acute kidney injury are covered separately in Section 13: Renal dialysis.

229. 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.

230. 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), providers may exclude the core HRG from their return and include all costs against the unbundled HRG.

Chemotherapy

231. Patients receive a core HRG and one or more extra unbundled chemotherapy HRGs split into two categories:
   - HRGs for procurement of chemotherapy regimens according to cost band

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54 You should also refer to Standard CA5: Chemotherapy in the acute costing approaches standards. https://improvement.nhs.uk/resources/approved-costing-guidance-standards

55 You should also refer to Standard CM6: Critical care in the acute costing methods standards. https://improvement.nhs.uk/resources/approved-costing-guidance-standards
• HRGs for the delivery of chemotherapy regimens.

232. The activity measure for the chemotherapy procurement HRGs is the number of cycles\(^{56}\) of treatment, and the unit cost is per average cycle.

233. Chemotherapy procurement HRGs are designed to cover the cost of the entire procurement service and therefore, in contrast to unbundled high cost drugs (paragraph 193), the cost of each HRG should include pharmacy on-costs (including indirect costs and support costs) 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\(^{57}\) should also be included in these HRGs.

234. The definitions in Table 19 may assist with costing the chemotherapy delivery HRGs.

**Table 19: Chemotherapy delivery**

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


\(^{57}\) [www.england.nhs.uk/ourwork/pe/cdf/](www.england.nhs.uk/ourwork/pe/cdf/)
235. 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 that would otherwise be generated is diagnosis-driven.

236. 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, so providers should include any notional costs against the unbundled chemotherapy delivery HRGs.

237. 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.

238. Chemotherapy should be reported in one of 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
- other.

**Ordinary admissions**

239. 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 (see
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 a support cost to the core HRG.

**Figure 3: Reporting chemotherapy ordinary admissions**

<table>
<thead>
<tr>
<th>Core HRG</th>
<th>Chemotherapy procurement HRG</th>
<th>Chemotherapy delivery HRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report in elective or non elective sheet</td>
<td>Report separately when generated</td>
<td>No delivery HRG reported as not OPCS coded</td>
</tr>
</tbody>
</table>

**Day-case and regular day or night admissions**

240. 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 4).

**Figure 4: Reporting chemotherapy day cases and regular day or night attenders**

<table>
<thead>
<tr>
<th>Core HRG</th>
<th>Chemotherapy procurement HRG</th>
<th>Chemotherapy delivery HRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>SB97Z Zero cost</td>
<td>Report separately if recorded</td>
<td>Report separately</td>
</tr>
</tbody>
</table>

**Chemotherapy outpatients**

241. 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 5).
### Other settings for chemotherapy

242. This other category (which we have also provided for diagnostic imaging, high cost drugs, radiotherapy, rehabilitation and specialist care) recognises that unbundled HRGs are independent of setting. 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.

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

### Additional guidance on chemotherapy

244. Although it is rare, some patients may have two regimens delivered at one attendance, resulting 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 regimen alongside any other regimen they may be receiving.

245. Further guidance relating to the treatment of regimens not on the national list can be found in the OPCS-4 clinical coding instruction manual.\(^58\)

246. Patients receiving both an infusion and 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, eg administration of bisphosphonates. The costs of these should be attributed to the relevant core HRG and not included with the chemotherapy delivery HRG.

\(^{58}\) [https://isd.digital.nhs.uk/trud3/user/guest/group/0/pack/10](https://isd.digital.nhs.uk/trud3/user/guest/group/0/pack/10)
247. 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, ie 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.

248. 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 only of drugs administered orally, and the costs should reflect current practice in light of recommendations in the National Patient Safety Agency (NPSA) report on oral chemotherapy.\(^{59}\)

249. 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.

250. 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 in these HRGs, as outlined in Table 20.

**Table 20: Supportive and hormonal drug treatment**

<table>
<thead>
<tr>
<th>Method of delivery</th>
<th>Hormone treatments</th>
<th>Supportive drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>As an intrinsic part of a regimen</td>
<td>If included within a regimen then ignore, because the costs are already included in the chemotherapy procurement HRGs.</td>
<td>If included within a regimen then ignore, because the costs are already included within the chemotherapy procurement HRGs.</td>
</tr>
</tbody>
</table>

\(^{59}\) [www.nrls.npsa.nhs.uk/resources/?entryid45=59880](http://www.nrls.npsa.nhs.uk/resources/?entryid45=59880) (Note: NPSA is now part of NHS Improvement.)
<table>
<thead>
<tr>
<th>Method of delivery</th>
<th>Hormone treatments</th>
<th>Supportive drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>By itself</td>
<td>Code to the relevant admitted patient or outpatient core HRG generated (not chemotherapy specific).</td>
<td>Apportion over procurement bands, potentially extra delivery time and costs.</td>
</tr>
<tr>
<td>As part of supportive drug</td>
<td>Include costs within supportive drug costs.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

PLICS: Treatment for chemotherapy

**Ordinary admissions**

251. The costs for chemotherapy delivery that occurs in ordinary admissions, elective or non-elective, should be reported in the APC extract with the collection activity chemotherapy delivery. Costs for the chemotherapy procurement must be excluded from the APC extract for PLICS and reported in the reference costs workbook only in accordance with the guidance above.

**Chemotherapy outpatients, day-case and regular day or night admissions**

252. Same-day chemotherapy episodes, outpatient attendances and chemotherapy procurement costs must not be reported in the patient-level extracts for PLICS. These must be reported in the reference costs workbook only.

253. Where there is a zero or minimal cost to be allocated against a core HRG as a result of unbundling costs in PLICS, providers may exclude the core HRG from their PLICS return and include all costs against the unbundled HRGs in the reference costs workbook.
Critical care

Introduction to critical care

254. Critical care reference costs are collected separately for:

- adult critical care
- paediatric critical care
- neonatal critical care.

255. A patient who is admitted to hospital will have an admitted patient care (APC) dataset record for their hospital admission, which will produce a core HRG and may also produce unbundled HRGs, eg for high cost drugs or diagnostic imaging. Patients admitted to any critical care facility as defined by the Data Dictionary\textsuperscript{60} must, in addition to their APC record, have a critical care minimum dataset record, which will produce an unbundled critical care HRG per critical care bed day. The critical care datasets are:

- critical care minimum dataset (CCMDS)\textsuperscript{61}
- paediatric critical care minimum dataset (PCCMDS; version 2.0)\textsuperscript{62}
- neonatal critical care minimum dataset (NCCMDS; version 2.0).\textsuperscript{63}

Critical care periods

256. The number of critical care periods\textsuperscript{64} that have occurred in each hospital spell are also collected within the critical care worksheet. A critical care period is a continuous period of care or assessment (ie a period of time) within a hospital provider spell during which a patient receives critical care in a ward or unit with a valid critical care unit function code.\textsuperscript{65} A new critical care period begins with each new admission or with a transfer between wards/units with different unit function definitions.

\textsuperscript{60} www.datadictionary.nhs.uk/data_dictionary/attributes/c/cou/critical_care_unit_function_de.asp?shownav=0
\textsuperscript{62} http://content.digital.nhs.uk/isce/publication/scci0076
\textsuperscript{63} http://content.digital.nhs.uk/isce/publication/scci0075
\textsuperscript{64} www.datadictionary.nhs.uk/data_dictionary/classes/c/critical_care_period_de.asp?shownav=1
\textsuperscript{65} Critical care unit function definitions are available at: www.datadictionary.nhs.uk/data_dictionary/attributes/c/cou/critical_care_unit_function_de.asp?shownav=0
function codes. Each critical care period will have its own minimum dataset record.

257. 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 21. All bed days for completed FCEs at the end of the reporting period should be counted.

Table 21: Critical care bed day count

<table>
<thead>
<tr>
<th>Patient with different dates of critical care admission and discharge</th>
<th>Critical care admission date and time</th>
<th>Critical care discharge date and time</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 November 13:00</td>
<td>7 November 10:30</td>
<td>3 critical care bed days</td>
<td></td>
</tr>
<tr>
<td>Patient with same date of critical care admission and discharge</td>
<td>5 November 13:00</td>
<td>5 November 22:00</td>
<td>1 critical care bed day</td>
</tr>
</tbody>
</table>

258. 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. On a day where a patient is transferred between critical care wards that have different critical care unit functions codes, one bed day should be counted for each unit function type.

Costing critical care

259. The costs for stays in critical care should be included in the per-bed-day critical care HRGs and not in the composite cost and length of stay for the admitted patient care core HRG. The key principle is that critical care represents the highest level of complexity, and only the daily costs of providing critical care (care activity described by the critical care minimum dataset data) should be recorded against the unbundled critical care HRG. Meanwhile, costs relating to treating the patient's condition (captured by OPCS and ICD-10 codes as part of the main APC data), including any surgery or theatre irrespective of setting, should be reported against the core HRG.

260. We would expect the following costs to be included in the cost per critical care bed day:
• medical staff
• nursing and other clinical staff
• therapies
• ward consumables
• drugs (excluding high cost drugs)
• blood and blood products (excluding high cost drugs)
• costs for diagnostics undertaken while the patient is in critical care where the costs are not covered in the core HRG, eg critical care nursing staff accompanying a patient to a scan
• medical and surgical equipment.

261. 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 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.

262. 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 HRGs are excluded (paragraph 69).

263. The costs of relevant high cost drugs or high cost blood products should be included in the unbundled high cost drugs HRGs (paragraph 297) and not in the critical care HRGs.

264. Costs for critical care days that produce an unbundled HRG of UZ01Z should be reported against UZ01Z and not apportioned elsewhere.

**Adult critical care**

265. Adult critical care HRGs are based on the total number of organs supported in a critical care period. The CCMDS collects a wider range of organ support information. Reference costs use these organ support categories to classify cost and activity data.
266. 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.

267. Reference costs for adult critical care are differentiated by all critical care unit functions\(^{66}\) in the CCMDS:

- 01 Non-specific, general adult critical care patients predominate
- 02 Surgical adult patients (unspecified specialty)
- 03 Medical adult patients (unspecified specialty)
- 05 Neurosciences adult patients predominate
- 06 Cardiac surgical adult patients predominate
- 07 Thoracic surgical adult patients predominate
- 08 Burns and plastic surgery adult patients predominate
- 09 Spinal adult patients predominate
- 10 Renal adult patients predominate
- 11 Liver adult patients predominate
- 12 Obstetric and gynaecology critical care patients predominate
- 90 Non-standard location using a ward area
- 91 Non-standard location using the operating department.

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

269. 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.

270. Data for children treated in adult critical care units will generate adult critical care HRGs. Activity and costs should be reported as part of the adult critical care costs.

271. 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

\(^{66}\) [www.datadictionary.nhs.uk/data_dictionary/attributes/c/cou/critical_care_unit_function_de.asp?shownav=1]
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/PACE teams as an overhead to admitted patient care, and not report them as a separate total cost.

Paediatric critical care

272. The 2018 national cost collection requires submission of paediatric critical care costs by the critical care functions, in accordance with the Data Dictionary.\(^{67}\)

- 04 Paediatric intensive care unit (paediatric critical care patients predominate)
- 16 Ward for children and young people
- 17 High dependency unit for children and young people
- 18 Renal unit for children and young people
- 19 Burns unit for children and young people
- 92 Non-standard location using the operating department for children and young people.

273. Trusts that cannot differentiate their costs should use national code 04.

274. Costs should be reported against the unbundled HRGs XB01Z to XB09Z, which are supported by version 2.0 of the PCCMDS.\(^{68}\) Details of these HRGs are:

- **XB01Z** is solely for use for extracorporeal membrane oxygenation (ECMO) or extracorporeal life support (ECLS), which are nationally commissioned from the designated providers listed in Table 22. It is therefore expected that most activity and costs will be reported by the providers in Table 22. However, any provider whose data generate this HRG should report activity and costs for this.

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\(^{67}\) [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)

\(^{68}\) [http://content.digital.nhs.uk/media/22151/00761132015spec/pdf/00761132015spec.pdf](http://content.digital.nhs.uk/media/22151/00761132015spec/pdf/00761132015spec.pdf)
Table 22: Providers of ECMO, ECLS or aortic balloon pump

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBS</td>
<td>Alder Hey Children's NHS Foundation Trust</td>
</tr>
<tr>
<td>RQ3</td>
<td>Birmingham Women's and Children's NHS Foundation Trust</td>
</tr>
<tr>
<td>RP4</td>
<td>Great Ormond Street Hospital for Children NHS Foundation Trust</td>
</tr>
<tr>
<td>RJ1</td>
<td>Guy's and St Thomas' NHS Foundation Trust</td>
</tr>
<tr>
<td>RR8</td>
<td>Leeds Teaching Hospitals NHS Trust</td>
</tr>
<tr>
<td>RT3</td>
<td>Royal Brompton &amp; Harefield NHS Foundation Trust</td>
</tr>
<tr>
<td>RTD</td>
<td>The Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>RHM</td>
<td>University Hospital Southampton NHS Foundation Trust</td>
</tr>
<tr>
<td>RA7</td>
<td>University Hospitals Bristol NHS Foundation Trust</td>
</tr>
<tr>
<td>RWE</td>
<td>University Hospitals of Leicester NHS Trust</td>
</tr>
</tbody>
</table>

- **XB02Z to XB05Z** relate to intensive care. The providers in Table 23 have paediatric intensive care units (PICU), and are therefore expected to account for most activity and cost in these HRGs. These providers would be expected to return reference costs for all HRGs (XB02Z to XB09Z), and not to assign costs to a limited number of HRGs.

Table 23: Providers with paediatric intensive care units

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBS</td>
<td>Alder Hey Children's NHS Foundation Trust</td>
</tr>
<tr>
<td>R1H</td>
<td>Barts Health NHS Trust</td>
</tr>
<tr>
<td>RQ3</td>
<td>Birmingham Women's and Children's NHS Foundation Trust</td>
</tr>
<tr>
<td>RGT</td>
<td>Cambridge University Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>RW3</td>
<td>Manchester University NHS Foundation Trust</td>
</tr>
<tr>
<td>Code</td>
<td>Name</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>RP4</td>
<td>Great Ormond Street Hospital for Children NHS Foundation Trust</td>
</tr>
<tr>
<td>RJ1</td>
<td>Guy's and St Thomas' NHS Foundation Trust</td>
</tr>
<tr>
<td>RWA</td>
<td>Hull and East Yorkshire Hospitals NHS Trust</td>
</tr>
<tr>
<td>RYJ</td>
<td>Imperial College Healthcare NHS Trust</td>
</tr>
<tr>
<td>RZJ</td>
<td>King's College Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>RR8</td>
<td>Leeds Teaching Hospitals NHS Trust</td>
</tr>
<tr>
<td>RX1</td>
<td>Nottingham University Hospitals NHS Trust</td>
</tr>
<tr>
<td>RTH</td>
<td>Oxford University Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>RT3</td>
<td>Royal Brompton &amp; Harefield NHS Foundation Trust</td>
</tr>
<tr>
<td>RCU</td>
<td>Sheffield Children's NHS Foundation Trust</td>
</tr>
<tr>
<td>RTR</td>
<td>South Tees Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>RJ7</td>
<td>St George's University Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>RTD</td>
<td>The Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>RHM</td>
<td>University Hospital Southampton NHS Foundation Trust</td>
</tr>
<tr>
<td>RJE</td>
<td>University Hospitals of North Midlands NHS Trust</td>
</tr>
<tr>
<td>RA7</td>
<td>University Hospitals Bristol NHS Foundation Trust</td>
</tr>
<tr>
<td>RWE</td>
<td>University Hospitals of Leicester NHS Trust</td>
</tr>
</tbody>
</table>

- **XB06Z to XB07Z** relate to high dependency care. This care can be delivered on children’s wards, as well as in designated high dependency and intensive care units. All providers whose PCCMDS data generates these HRGs should submit these costs.
- **XB08Z** relates to paediatric critical care transport.
- **XB09Z** relates to paediatric critical care, enhanced care. It represents the resources involved in providing critical care in a PICU or HDU to children who do not trigger any of the PCCMDS activity codes required for grouping to XB01Z to XB07Z.

275. HRGs XB06Z to XB07Z and XB09Z can be derived in a variety of settings. Therefore costs for delivery of critical care on children's wards should be included and underpinned by the completion of a PCCMDS record. Take care to ensure these costs are not double-counted against the admitted patient care core HRG. It is expected that activity occurring in children's wards would be limited to XB06Z to XB07Z.

276. Unit costs for XB01Z to XB07Z and XB09Z are per occupied bed day (applying the counting convention in paragraphs 256 and 257), with each occupied bed day producing an HRG (ie one HRG per day).

277. Unit costs for XB08Z are per patient journey.

278. In 2006, the National Casemix Service analysed the results of an observational study of staff resource costs in 10 PICUs. The work is discussed in the *National report of the Paediatric Intensive Care Audit Network (PICANET), January 2004 – December 2006*. 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 24 below. In this example, we assume a hypothetical PICU 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 24: Using benchmark cost ratios to inform paediatric critical care reference costs

<table>
<thead>
<tr>
<th>HRG</th>
<th>Description</th>
<th>A</th>
<th>B</th>
<th>C = A * B</th>
<th>D = C/£10 million</th>
<th>E = D/B</th>
</tr>
</thead>
<tbody>
<tr>
<td>XB01Z</td>
<td>Paediatric critical care, advanced critical care 5</td>
<td>3.06</td>
<td>100</td>
<td>306</td>
<td>546,233</td>
<td>5,462</td>
</tr>
<tr>
<td>XB02Z</td>
<td>Paediatric critical care, advanced critical care 4</td>
<td>2.12</td>
<td>150</td>
<td>318</td>
<td>567,654</td>
<td>3,784</td>
</tr>
<tr>
<td>XB03Z</td>
<td>Paediatric critical care, advanced critical care 3</td>
<td>1.40</td>
<td>500</td>
<td>700</td>
<td>1,249,554</td>
<td>2,499</td>
</tr>
<tr>
<td>XB04Z</td>
<td>Paediatric critical care, advanced critical care 2</td>
<td>1.22</td>
<td>1,000</td>
<td>1,220</td>
<td>2,177,794</td>
<td>2,178</td>
</tr>
<tr>
<td>XB05Z</td>
<td>Paediatric critical care, advanced critical care 1</td>
<td>1.00</td>
<td>2,000</td>
<td>2,000</td>
<td>3,570,154</td>
<td>1,785</td>
</tr>
<tr>
<td>XB06Z</td>
<td>Paediatric critical care, intermediate critical care</td>
<td>0.91</td>
<td>750</td>
<td>683</td>
<td>1,219,207</td>
<td>1,626</td>
</tr>
<tr>
<td>XB07Z</td>
<td>Paediatric critical care, basic critical care</td>
<td>0.75</td>
<td>500</td>
<td>375</td>
<td>669,404</td>
<td>1,339</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td>5,000</td>
<td>5,602</td>
<td><strong>10,000,000</strong></td>
<td></td>
</tr>
</tbody>
</table>

279. Trusts may wish to use the cost ratios above to help compile their reference costs. However, the ratios are indicative, and if trusts can provide robust cost apportionments of their own, they should use these instead. The ratios were obtained from a study in 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 PICUs would be expected to be lower.

280. XB09Z was introduced to the HRG design after this costing analysis had been completed, and therefore no ratio is available to support costing. However, days in this HRG are expected to be roughly equivalent to ward-based care, ie a standard paediatric bed day.

281. HRG UZ01Z is available for data which is invalid for grouping.

**Neonatal intensive care**

282. Data from NCCMDS Version 2.0 (2016 release)\(^{70}\) must be used to inform the reporting of reference costs against the unbundled HRGs XA01Z to XA06Z from 2016/17 onwards.

283. In a change for the 2018 national cost collection, we will be expanding the neonatal intensive care sheet to collect data for these three neonatal facilities:

- 13 Neonatal intensive care unit
- 14 Facility for babies on a transitional care ward
- 15 Facility for babies on a maternity ward.

284. If trusts are unable to differentiate between the facility types, data must be submitted as unit 13, neonatal intensive care.

285. Unit costs for XA01Z to XA05Z are per occupied bed day (applying the counting convention in paragraphs 256 and 257), with each occupied bed day producing an HRG (ie one HRG per day).

286. XA06Z relates to neonatal critical care transport. The unit cost is per patient journey.

287. The HRGs are based on the British Association of Perinatal Medicine’s categories of care 2011 standards\(^{71}\) and use minimum required staffing levels to differentiate the anticipated resource-intensiveness of delivered care. Costs

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\(^{70}\) Version 2.0 of the NCCMDS was mandated for local recording from 1 December 2016. Appropriate annualisation of data for December 2016 to March 2017 must take place to ensure that activity and cost data reflect the full year.

\(^{71}\) [www.nna.org.uk/html/BAPM_Category%20of%20care%202011.pdf](www.nna.org.uk/html/BAPM_Category%20of%20care%202011.pdf)
(particularly staffing) should be apportioned to reflect the requirements of the different neonatal HRGs. As a guide, it would usually be expected that:

- the cost of XA01Z would be at least four times the cost of XA03Z
- the cost of XA02Z would be at least two times the cost of XA03Z
- the cost of XA03Z and XA04Z would be similar
- the cost of XA05Z would be lower than the cost of XA03Z/XA04Z but would not usually be expected to be less than the cost of providing a standard paediatric/neonatal bed day.

**PLICS: Treatment for critical care**

288. Critical care adult, neonatal and paediatric activity and costs must not be reported in the patient-level extracts for PLICS. These must be reported in the reference costs workbook only. This includes neonatal critical care transportation.

289. Where there is a zero or minimal cost to be allocated against a core HRG as a result of unbundling costs in PLICS, providers may exclude the core HRG from their PLICS return and include all costs against the unbundled HRGs in the reference costs workbook.

**Diagnostic imaging**

290. Diagnostic imaging should be reported separately when occurring in these settings:

- outpatients
- direct access
- other.

291. 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.
292. 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. Costs and activity for these scans should not be unbundled, but reported within the generated core HRG.

293. 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.

294. Diagnostic imaging should also be reported by the TFC of the outpatient clinic in which the imaging was requested. Providers should use code 812 if they are unable to assign a TFC accurately.

295. The unit cost is per examination.

**PLICS: Treatment for diagnostic imaging**

296. **All diagnostic imaging costs**, which are unbundled from outpatients in reference costs, are to be included in PLICS at patient level, but reported using the diagnostic imaging collection activities.

**High cost drugs**

297. In 2018 we will not be collecting high cost drugs at an HRG level. We will be asking you to submit the cost of the drug by its name, on a prescribed worksheet, in these patient categories:

- admitted patient care: unit cost per FCE
- outpatients: unit cost per attendance
- other settings: unit cost per attendance.

298. The costs submitted for high cost drugs should include only the actual costs of the drug. All other pharmacy on-costs, and the costs of drugs administered with high cost drugs, should remain in the core HRG.
To align the two collections, the national tariff high cost drugs exclusion list – contained in Annex A of the 2017/19 tariff\textsuperscript{72} – should be used to define which drugs are classed as high cost.

### PLICS: Treatment for high cost drugs

**300.** High cost drugs are unbundled for outpatients and admitted patient care in reference costs. However, for PLICS, high cost drugs must be reported using the appropriate collection activity at a patient level in the OP and APC extracts.

**301.** Where there is a zero or minimal cost to be allocated against a core HRG as a result of unbundling costs in PLICS, providers may exclude the core HRG from their PLICS return and include all costs against the unbundled HRGs in the reference costs workbook.

### High cost devices

**302.** In 2016 a new system for buying and supplying high cost medical devices in specialised services was introduced.\textsuperscript{73} The new system is operated by NHS Supply Chain. The approach is a transactional model. Rather than each provider paying for the devices and being reimbursed by NHS England as before, providers will place orders with NHS Supply Chain at zero cost to them. NHS Supply Chain will then place the order with suppliers and invoice NHS England.

**303.** The new system covers all ‘high cost tariff excluded devices’ set out in the list of high cost devices in the 2017/19 national tariff.\textsuperscript{74} These are expensive devices paid for on top of the national price (tariff), for the procedure in which they are used. This is because relatively few centres procure the devices, and we recognise that the costs would not be fairly reimbursed if they were simply funded through the tariff.

**304.** To ensure all providers cost the inpatient HRG in the same way, the costs of high cost devices listed in Annex A of the tariff document should be excluded from the HRG costs. The cost of these devices should be excluded in the

\textsuperscript{72} Worksheet 13b of Annex A: https://improvement.nhs.uk/resources/national-tariff-1719/

\textsuperscript{73} www.england.nhs.uk/commissioning/spec-services/key-docs/medical-devices/

\textsuperscript{74} Worksheet 13a of Annex A: https://improvement.nhs.uk/resources/national-tariff-1719/
reconciliation statement. The detail of the costs and numbers of devices should be included in the drugs and devices sheet as in previous years.

305. If you are unable to separately identify and exclude the costs of these high cost devices, please e-mail costing@improvement.nhs.uk so we are aware some costs may be inflated in your organisation.

306. Continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP) machines are not on the high cost devices list. The cost of these machines is usually under a pass-through agreement and the CCG pays the cost of these machines. The income for these machines should therefore net off to zero and not inflate the cost of the attendance.

307. Cardiology loop recorders are another type of device that is not on the high cost devices list, but has been queried during the submission process. Loop recorders are implantable, single use devices and therefore the cost of these should be matched to the patients who had one fitted. Therefore any loop recorders should be mapped to the patients who had the HRG EY12A or EY12B.

PLICS: Treatment for high cost devices

308. For PLICS, high cost devices must be identified and excluded from APC, OP and A&E patient-level extracts and reported in the reference costs reconciliation, in accordance with the guidance above.

309. Where there is a zero or minimal cost to be allocated against a core HRG as a result of unbundling costs in PLICS, providers may exclude the core HRG from their PLICS return and include all costs against the unbundled HRGs in the reference costs workbook.

Radiotherapy

310. The unbundled radiotherapy HRGs are similar to the design of the unbundled chemotherapy HRGs, in that an attendance may result in two extra 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 these settings for consistency:
• ordinary elective or non-elective admissions
• day case and regular day or night attendances
• outpatients
• other.

311. As well as these HRGs, a core HRG (SC97Z) for a same-day external beam radiotherapy admission or attendance is generated by the grouper if:

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

312. The principles described in paragraph 236 for SB97Z also apply to SC97Z.

313. Activity should be allocated for each fraction of radiotherapy delivered and only one fraction per attendance should be coded. The intention in HRG4+ is that each fraction would be separately counted, rather than the number of courses of treatments. However, clinical coding guidance states that only one delivery fraction should be recorded per stay.

314. 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.

315. Table 25 clarifies the grouper output for different patient settings (if providers have followed coding guidance) and the treatment of the data for reference costs.

Table 25: Radiotherapy outputs

<table>
<thead>
<tr>
<th>Setting</th>
<th>HRG output from the grouper</th>
<th>Treatment of HRG in reference costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordinary elective or non-elective admission</td>
<td>Core HRG + Planning HRG (one coded per admission)</td>
<td>Report core HRG costs separately from radiotherapy costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Report planning costs using planning HRGs</td>
</tr>
<tr>
<td>Setting</td>
<td>HRG output from the grouper</td>
<td>Treatment of HRG in reference costs</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Delivery HRG (one coded per admission)</td>
<td>Report all delivery costs for the admission using delivery HRG</td>
<td></td>
</tr>
<tr>
<td>SC97Z same-day external beam radiotherapy</td>
<td>Report SC97Z at zero cost (all radiotherapy costs are reported in planning or delivery activity)</td>
<td></td>
</tr>
<tr>
<td>Planning HRG (one coded per course of treatment)</td>
<td>Report unit cost of planning HRG per course of treatment</td>
<td></td>
</tr>
<tr>
<td>Delivery HRG (one coded per fraction delivered every appointment)</td>
<td>Report average cost per fraction and number of attendances</td>
<td></td>
</tr>
<tr>
<td>Other (for any activity not included above)</td>
<td>Report planning per course and delivery per fraction</td>
<td></td>
</tr>
</tbody>
</table>

316. 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.

317. 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.

318. Supportive care costs for cancer patients receiving radiotherapy in an ordinary elective or non-elective setting should be allocated as set out in paragraph 239.

319. Advice from the National Cancer Action Team (NCAT) highlights the need to allocate costs according to the type of radiotherapy being delivered. There are two main types of radiotherapy:

- external beam radiotherapy
- brachytherapy and liquid radionuclide administration.

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

**PLICS: Treatment for radiotherapy**

321. For PLICS, radiotherapy costs and activity must be identified and excluded from APC and OP patient-level extracts and reported in the reference costs workbook only, as per the guidance above.

322. Where there is a zero or minimal cost to be allocated against a core HRG as a result of unbundling costs in PLICS, providers may exclude the core HRG from their PLICS return and include all costs against the unbundled HRGs in the reference costs workbook.

**Rehabilitation**

323. 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 15: Mental health services and not here.

324. Unbundled rehabilitation HRGs are only generated where care is identified as taking place under a specialist rehabilitation consultant or within a discrete rehabilitation unit.

325. 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 6 illustrates the grouper output and the reporting requirements for reference costs.
326. Rehabilitation should be reported under one of these settings:

- admitted patient care: unit cost per occupied bed day
- outpatient: unit cost per attendance
- other.

327. Each setting is further divided as follows:

- complex specialised rehabilitation services (CSRS) – level 1
- specialist rehabilitation services – level 2
- non-specialist rehabilitation services – level 3.

**Complex specialised rehabilitation services**

328. Certain aspects of rehabilitative care are delivered by specialist NHS providers. An expectation of increased use of resources and longer durations of admitted patient care is associated with the delivery of complex specialised and specialist rehabilitation. 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 specialised services national dataset (SSNDS), \(^{76}\) the collection requires that the NHS separately identifies not only those complex specialised rehabilitation services, but also those that might be termed specialist.

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\(^{76}\) [http://content.digital.nhs.uk/casemix/prescribedspecialisedservices]
329. CSRS that fall within this definition set and contain components relating to admitted patient rehabilitation are:

- specialised spinal services (all ages)
- specialised rehabilitation services for brain injury and complex disability (adult)
- specialised burn care services (all ages)
- specialised pain management services (adult).

**Specialist rehabilitation services**

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

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

331. BSRM has developed criteria and checklists for identifying level 2 services that conform to the standards required of a specialist rehabilitation service. These may be applied by peer review and benchmarking reported data to confirm service quality.

**Non-specialist rehabilitation services**

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

333. 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.

334. 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 (ie 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 (ie 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 while in an acute stage of treatment to facilitate early discharge, but still require acute care and stabilisation before rehabilitation treatment, providers 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.

335. 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.

PLICS: Treatment for rehabilitation

336. For PLICS, rehabilitation costs and activity must be identified and excluded from APC and OP patient-level extracts and reported in the reference costs workbook only, in accordance with the guidance above.

337. Where there is a zero or minimal cost to be allocated against a core HRG as a result of unbundling costs in PLICS, providers may exclude the core HRG from
their PLICS return and include all costs against the unbundled HRGs in the reference costs workbook.

Specialist palliative care

338. 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
- other.

339. The unbundled HRGs include care 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).

340. 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 a support cost.

Ordinary admissions

341. 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.

342. 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 contact using HRG SD03*. The core HRG length of stay should not be adjusted for specialist palliative care support.
343. This is a change in the reported activity for specialist palliative care support (SD03* HRG); previously it was bed days. This was incorrect and resulted in different data being recorded for HRG SD03*.

344. The activity and costs submitted for HRG SD03* should be for face-to-face and non face-to-face support contacts by the specialist palliative care team with the patient. Advice and guidance contacts between the specialist palliative care team and the doctor or nurse responsible for the patient’s care should also be included in SD03*. Where providers have not recorded contact information in 2017, they should either estimate the contact activity, or report the activity and cost data using the current method.

345. You may need to talk to your specialist palliative care team to acquire local data feeds or contact information, as it may not be collected by the informatics department.

346. For 2019 reference costs, please contact your palliative care teams to see what information they can capture on contacts from 1 April 2018, as we intend to introduce the reporting of contacts for all providers in the 2018/19 national cost collection guidance for SD03* HRG.

**Day case and regular day or night attenders**

347. Same-day specialist palliative care should be reported under HRG SD02*. The grouper will automatically add one bed day.

**Outpatients**

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

**PLICS: Treatment for specialist palliative care**

349. For PLICS, specialist palliative care costs and activity must be identified and excluded from APC and OP patient-level extracts and reported in the reference costs workbook only, as per the guidance above.
350. Where there is a zero or minimal cost to be allocated against a core HRG as a result of unbundling costs in PLICS, providers may exclude the core HRG from their PLICS return and include all costs against the unbundled HRGs in the reference costs workbook.
13: Renal dialysis

Introduction

351. This section applies to renal dialysis for chronic kidney disease and acute kidney injury. We have been in contact with the clinician-led renal dialysis expert working group, which has been analysing the costing of renal dialysis.

352. This group assessed previously issued guidance and enhanced it to help improve submission of reference costs. Because of the complexity of renal services, we strongly encourage engagement with clinical teams when costing this service.

353. We also hope that accurate costing, as detailed in this guidance, will be useful to local renal teams as well as the national reference costing groups. The expert working group is now doing more to assess these costs in more detail and to try to understand any differences in cost of renal dialysis HRGs and activity classification across the sector.

354. Standard CA3: Renal dialysis⁷⁷ has detailed information about renal dialysis which should be read alongside this section.

Renal dialysis for chronic kidney disease

355. Chronic kidney disease reduces the kidneys’ ability to carry out their functions in the long term. It is most often caused by damage to the kidneys from other conditions, most commonly diabetes and high blood pressure. The only cure is a kidney transplant but most people with end-stage kidney failure require dialysis treatment to partly replace kidney function.

356. Renal dialysis for chronic kidney disease is described by the subchapter LD core HRGs. These are generated from data items contained in the national renal dataset (NRD).

⁷⁷ See acute costing approaches standards: https://improvement.nhs.uk/resources/approved-costing-guidance-standards
357. When a patient has dialysis for chronic kidney disease, some providers record a dialysis session (patient solely admitted for dialysis) as an outpatient or regular day admission within the CDS. This should generate the subchapter 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 to remove the possibility of double-counting in the submission) for the CDS activity.

**Haemodialysis**

358. 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 by each patient. Home haemodialysis is costed as a separate HRG and is costed per week of treatment.

359. There are some points to remember when completing a costing template. Several HRGs represent facility-based haemodialysis activity, but they vary depending on location and vascular access type.

- HRGs distinguish between hospital and satellite-based haemodialysis but current reimbursement is identical. However, it is likely that the costs associated with treatment in different locations will differ. This will be particularly relevant if part of the service is provided under contract by private provider dialysis companies. We therefore suggest that each location is considered separately so that support costs, etc. can be apportioned correctly. However, resources applicable to all locations need to be apportioned as per activity. This is likely to need clinical guidance.

- There is a best practice tariff for dialysis. This is to encourage use of a fistula rather than a catheter. It does not reflect the cost of the process, and this differential in income should not be used to influence the costing of the different types of vascular access.

360. 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.

361. Where separate costs for patients with blood-borne viruses (BBV) 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 use. Extra resource may also be provided to patients returning from holiday, and will be monitored in case of risk of a BBV.

362. There are extra requirements to:

- separately identify the costs and activity associated with providing haemodialysis to patients aged 19 years and over while 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. Providers will need to liaise with their renal unit to get this information. Costs should be provided on the same basis as for regular dialysis at the base unit
- report as memorandum information the average number of sessions per week per patient of home haemodialysis for patients aged 19 years and over. Providers will need to liaise with their renal unit to get this information.

### Peritoneal dialysis

363. HRGs LD11* to LD13* describe peritoneal dialysis. The unit cost is per day as described in the NRD, and not per number of bags or exchanges. The bags used for each session are a major cost driver. They can differ in size, so using the 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 automated peritoneal dialysis (APD) should be included. If an assisted APD service is provided, costing should include all the costs of home visits, whether made by the provider or an external company.

### Renal dialysis for acute kidney injury

364. Renal dialysis for acute kidney injury is described by unbundled subchapter LE, containing HRGs split between haemodialysis (HD) and peritoneal dialysis (PD) for adults and children. It is important to ensure that costs for acute dialysis are not apportioned to the chronic dialysis codes since these are reimbursed separately.
365. Where a patient is located on a renal ward as an inpatient for acute kidney injury or chronic HD, which will have a core HRG cost, and also receiving dialysis sessions that would be costed and submitted separately, costing teams should discuss with clinical teams how to divide all costs so that staffing, consumables and support costs are distributed according to relative proportions of each activity. Costing teams need to be aware that dialysis units may also perform other therapies such as plasma exchange. Costs associated with these non-dialytic therapies should not be included in dialysis reference costs.

366. 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 have other primary diagnoses and treatments, so the LE unbundled HRGs can be generated alongside any core HRG.

367. Each dialysis session 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

368. Admitted patient care costs for renal medicine should be mapped according to admitted patient care cost pools and not to renal dialysis, except where these costs are directly related to dialysis in admitted patient care.

369. The costs should include all the necessary consumables to deliver the dialysis therapy, whether that is haemodialysis or peritoneal dialysis. 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), pharmacy and medical engineering or technical staff.

370. Providers should identify costs related to nutrition and dietetic staff, psychology services and social work where these are delivered at the point of dialysis. Contacts with support staff may be counted as outpatients (single professional or as part of a multiprofessional episode) or may be costed as part of the renal dialysis session. It is important to cost them as they are delivered within your organisation to enable benchmarking to show the difference in practice between providers.

371. For home dialysis modalities, cost of staff travel to allow home support should be included.
372. Costs related to necessary IT infrastructure should be included, recognising the bespoke systems required by renal services. This should be included either in provider support costs and/or as a specific budget line, depending on service provision. This should include the mandatory requirements to return data to the UK Renal Registry via the capitation fee.

373. Costs should also include the revenue costs of buying and maintaining buildings and equipment, allocated appropriately between the different types of dialysis. This should cover the costs of dialysis equipment, whether as capital depreciation, lease cost or on a cost per treatment basis, including dialysis machines and all other equipment needed for dialysis. For home therapies, conversion costs and reimbursement for utilities to people who undertake treatment at home (eg excess electricity and water use, telephone for emergency use) must be included.

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

375. 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.

**Renal dialysis drugs**

376. To ensure that high cost drugs reported in reference costs reflect the high cost drugs list in worksheet 13b, Annex A of the 2017/19 national tariff, we ask you this year to unbundle all high costs regardless of setting. If any of the drugs detailed in the guidance below are on the national tariff high cost drugs list, report them as such.

377. The costs of all ESAs and drugs for bone mineral disorders prescribed by the provider should be included in the LD HRG costs. Providers often have a ‘pass through’ agreement with their commissioners, so it is important not to include these costs in the ‘homecare drugs’ cost in the reconciliation statement. Some

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78 [https://improvement.nhs.uk/resources/national-tariff-1719/](https://improvement.nhs.uk/resources/national-tariff-1719/)
of these drugs should **also** be reported separately in the drugs and devices worksheet, including all the following:

- the ESAs Epoetin alpha, beta and zeta, and Darbepoetin alpha
- the drugs for bone mineral disorders Cinacalcet, Sevelamer and Lanthanum if provided by the provider.

378. Patients sometimes require 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.

**Renal patient transport services**

379. 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.

**PLICS: Treatment for renal dialysis**

380. For PLICS, Renal dialysis should be identified and excluded from APC and OP patient-level extracts and reported in the reference costs workbook, in accordance with the guidance above.

381. Where there is a zero or minimal cost to be allocated against a core HRG as a result of unbundling costs in PLICS, providers may exclude the core HRG from their PLICS return and include all costs against the renal dialysis HRGs in the reference costs workbook.
14: Direct access services

Introduction to direct access services

382. This section covers these direct access services.79

- diagnostic services
- pathology services.

383. Diagnostic or pathology services undertaken in admitted patient care, critical care, outpatients or accident and emergency 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

384. 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,80 and providers should report them using the relevant HRGs.

385. Plain film X-rays are not unbundled in any setting, and the composite costs should be included in 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.

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79 www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/direct_access_service_de.asp?shownav=1
80 www.datadictionary.nhs.uk/data_dictionary/attributes/d/den/direct_access_referral_indicator_de.asp?shownav=1
Pathology services

386. 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\(^\text{81}\) required as a memorandum item:

- cytology (excluding cervical screening programmes)
- histopathology and histology
- integrated blood sciences services (including clinical biochemistry, haematology and immunology)
- clinical biochemistry
- haematology
- immunology
- microbiology (including bacteriology, virology and mycology)
- phlebotomy
- other.

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

388. Providers should refer to the National Laboratory Medicine Catalogue, a catalogue of pathology tests designed to support consistent, standardised reporting, which is available via the Technology Reference Data Update Distribution Service (TRUD).\(^\text{82}\)

389. DH (now DHSC), NHS Midlands and East also produced a toolkit to support commissioning of community (ie direct access) pathology services.\(^\text{83}\) Although it is primarily intended for commissioners, providers of pathology services may find some of the tools helpful.

390. 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.

\(^\text{81}\) www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/r/request_for_pathology_investigation_de.asp?shownav=1
\(^\text{82}\) https://isd.digital.nhs.uk/trud3/user/guest/group/0/pack/25/subpack/77/releases
PLICS: Treatment for direct access services

391. For PLICS, direct access costs should be identified but not reported at a patient level. Direct access costs must be reported in the reference costs workbook only, in accordance with the guidance above.
15: Mental health services

Introduction

392. This section covers:

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

393. Mental health providers should also use currencies described elsewhere in this guidance for services not included here. For example, forensic psychiatry outpatients should be reported against TFC 712, as described in Section 9: Outpatient services.

394. 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 of Health (now the Department of Health and Social Care), and this guidance should be read alongside Monitor and NHS England’s Guidance and mental health currencies and payment document.\(^\text{84}\)

395. 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.

396. Table 26 summarises the allocation of mental health services within the reference cost currencies.

Table 26: Allocation of mental health services within reference costs

<table>
<thead>
<tr>
<th>Service</th>
<th>Included in cluster reference costs</th>
<th>Included in non-cluster reference costs</th>
<th>Excluded from reference costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved social worker services*</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assertive outreach teams</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling and therapy**</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Crisis accommodation services</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer support services (if costs cannot be separately allocated to individual patients this cost should be treated as a support cost)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis resolution and home treatment teams</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early intervention in psychosis services from age 14</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating disorder services (adult, excluding specialised eating disorders)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency clinics or walk-in clinics</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency duty teams (which are not emergency assessments, eg for sectioning under the Mental Health Act)*</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless mental health services</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local psychiatric intensive care units</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychology **</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Psychotherapy **</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Psychiatric liaison services including A&amp;E liaison, acute hospital liaison, nursing home liaison, etc</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult specialist eating disorder services</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism and Asperger syndrome</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug and alcohol services</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating disorder services (children and adolescents)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Included in cluster reference costs</td>
<td>Included in non-cluster reference costs</td>
<td>Excluded from reference costs</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Forensic and secure mental health services: inpatients</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Forensic outpatients</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Gender identity disorder services</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning disability services in high dependency or high secure units</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health services for deaf children and adolescents</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health services for military veterans</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health services provided under a GP contract</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal mental health services (mother and baby units)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary diagnosis of drug or alcohol misuse</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialised addiction services</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist mental health services for deaf adults</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist psychological therapies (admitted patients and specialised outpatients)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquired brain injury</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disability services not provided in high dependency or high secure units</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Neuropsychiatry</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

* These services are only included in clusters where NHS funded, otherwise they are excluded.
** 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.
397. The collection and guidance are therefore organised from the perspective of patients\(^85\) and the settings in which mental health services are delivered. For non-cluster activity, the following settings apply:

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

**Adult mental health services**

**Mental health care clusters**

398. The mental health care clusters\(^86\) for working age adults and older people focus on the characteristics and needs of a patient 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 to 21, although 09 is not currently used and 99 is used for patients not assessed or clustered.

399. In 2015 the Department of Health introduced 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 enabled providers to separate unfinished assessment episodes (work in progress – WIP) from assessments ending in discharge of the patient back to the GP or to another more appropriate treatment provider.

400. Mental health professionals code patients using the mental health clustering tool (MHCT) which helps them determine which cluster best describes the characteristics of a particular patient.

\(^85\) People receiving care from a mental health provider are usually referred to as service users or clients by healthcare professionals. However, as this costing work is for costing practitioners and their aim is to improve quality of patient-level costing in an organisation, the technical focus group agreed that we should refer to anyone accessing mental health services as a patient.

\(^86\) [www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_care_cluster_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_care_cluster_de.asp?shownav=1)
401. Providers must use the MHCT and mental health clustering tool booklet. The clustering tool must be used to help inform the clustering decision, and the information that is captured must be returned with other data as part of the monthly submission to the mental health minimum dataset (MHMDS).

402. The clusters cover extended time periods that will often contain multiple different care interventions. For instance, while in Cluster 3 (non-psychotic (moderate severity)) a patient might have several sessions of psychological therapies, contacts with a care co-ordinator and a prescription for exercise. Each cluster has an associated review period, defined as the time between reassessments. This should be taken as a **maximum rather than a minimum** period. However, if there is a reassessment before the maximum review period, because of a change in the patient’s condition, this becomes the actual cluster review period for that patient.

403. Table 27 shows the clusters and their maximum review period.

**Table 27: Mental health care clusters**

<table>
<thead>
<tr>
<th>Code</th>
<th>Cluster label</th>
<th>Cluster review period (maximum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Variance – unable to assign mental health care cluster code</td>
<td>6 months</td>
</tr>
<tr>
<td>01</td>
<td>Common mental health problems (low severity)</td>
<td>12 weeks</td>
</tr>
<tr>
<td>02</td>
<td>Common mental health problems (low severity with greater need)</td>
<td>15 weeks</td>
</tr>
<tr>
<td>03</td>
<td>Non-psychotic (moderate severity)</td>
<td>6 months</td>
</tr>
<tr>
<td>04</td>
<td>Non-psychotic (severe)</td>
<td>6 months</td>
</tr>
<tr>
<td>05</td>
<td>Non-psychotic (very severe)</td>
<td>6 months</td>
</tr>
<tr>
<td>06</td>
<td>Non-psychotic disorders of over-valued ideas</td>
<td>6 months</td>
</tr>
<tr>
<td>07</td>
<td>Enduring non-psychotic disorders (high disability)</td>
<td>Annual</td>
</tr>
<tr>
<td>08</td>
<td>Non-psychotic chaotic and challenging disorders</td>
<td>Annual</td>
</tr>
</tbody>
</table>

---

87 Annex 7C in the consultation documents published at [www.monitor.gov.uk/NT](http://www.monitor.gov.uk/NT)
<table>
<thead>
<tr>
<th>Code</th>
<th>Cluster label</th>
<th>Cluster review period (maximum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>09</td>
<td>Blank cluster&lt;sup&gt;88&lt;/sup&gt;</td>
<td>Not applicable</td>
</tr>
<tr>
<td>10</td>
<td>First episode in psychosis</td>
<td>Annual</td>
</tr>
<tr>
<td>11</td>
<td>Ongoing recurrent psychosis (low symptoms)</td>
<td>Annual</td>
</tr>
<tr>
<td>12</td>
<td>Ongoing or recurrent psychosis (high disability)</td>
<td>Annual</td>
</tr>
<tr>
<td>13</td>
<td>Ongoing or recurrent psychosis (high symptom and disability)</td>
<td>Annual</td>
</tr>
<tr>
<td>14</td>
<td>Psychotic crisis</td>
<td>4 weeks</td>
</tr>
<tr>
<td>15</td>
<td>Severe psychotic depression</td>
<td>4 weeks</td>
</tr>
<tr>
<td>16</td>
<td>Dual diagnosis (substance abuse and mental illness)</td>
<td>6 months</td>
</tr>
<tr>
<td>17</td>
<td>Psychosis and affective disorder (difficult to engage)</td>
<td>6 months</td>
</tr>
<tr>
<td>18</td>
<td>Cognitive impairment (low need)</td>
<td>12 months</td>
</tr>
<tr>
<td>19</td>
<td>Cognitive impairment or dementia (moderate need)</td>
<td>6 months</td>
</tr>
<tr>
<td>20</td>
<td>Cognitive impairment or dementia (high need)</td>
<td>6 months</td>
</tr>
<tr>
<td>21</td>
<td>Cognitive impairment or dementia (high physical need or engagement)</td>
<td>6 months</td>
</tr>
<tr>
<td>IA98</td>
<td>Patient assessed but not accepted into service</td>
<td>N/A</td>
</tr>
<tr>
<td>99</td>
<td>Patients not assessed or clustered</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Costing the mental health care clusters**

404. Mental health providers should cost their services to the same costing principles set out in the Approved Costing Guidance<sup>89</sup> that apply to all NHS providers, and to the costing standards set out in the mental health costing standards.<sup>90</sup>

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<sup>88</sup> Cluster 09 will not be available in the workbook

<sup>89</sup> See [The costing principles](https://improvement.nhs.uk/resources/approved-costing-guidance/)

<sup>90</sup> [https://improvement.nhs.uk/resources/approved-costing-guidance-standards](https://improvement.nhs.uk/resources/approved-costing-guidance-standards)
405. The key to costing accurately at cluster level is having the activity and interventions recorded by patient and the cluster allocated appropriately. This means costs can be built up by patient and then by cluster.

406. In line with the guidance for non-cluster mental health costs, the costs of teams providing activity to clustered patients 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.

407. The initial assessment period begins when a mental health provider receives a new referral from a GP or elsewhere. The activity count for initial assessments is number of patients assessed. Experience to date suggests that this initial assessment will normally be completed within two contacts or on admission to an inpatient setting. The assessment is completed when the individual is either allocated to a cluster, admitted to a ward, or not allocated – for example, discharged (cluster IA98). Therefore we would not expect providers to have any inpatient costs within the initial assessment charge; however, we are aware that in some providers, initial assessment does occur in an inpatient setting. While a patient would normally be allocated to a cluster within two community contacts, this is not always the case and providers should include in the initial assessment charge all of the costs of contacts up to and including the contact where the cluster is allocated, regardless of how many contacts this may be.

408. 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 before clustering will be allocated to the appropriate cluster in service code MHCCIA.

409. 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 to a cluster, including the cost of their initial assessment on the initial assessment worksheet.

- **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.

- **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.

410. Once a patient has been assessed and placed in a cluster, the cost of the initial assessment is coded to the correct cluster in service code MHCCIA, not MHCC.

411. The cost of reassessment should be included in the cluster the patient is assigned to, at the time of the reassessment, rather than the new cluster if the cluster changes. Reassessment that does not result in a change of cluster will be recorded as a new review period.

412. Information on patients who did not attend (DNA) is not collected separately. Therefore, the costs, but not the activity, associated with DNAs should be included as support cost within the relevant cluster pathway. The same approach to DNAs applies to the non-cluster currencies.

### Mental health clusters

413. 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.

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

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

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 (ie 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.

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

417. Table 28 summarises the data we will collect for the mental health clusters.

**Table 28: Mental health care cluster worksheets**

<table>
<thead>
<tr>
<th>Field</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cluster costs (service code MHCC)</strong></td>
<td></td>
</tr>
<tr>
<td>Unit cost per day per cluster</td>
<td>Average/weighted cost per day per patient 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</td>
</tr>
<tr>
<td>Number of cluster days within the financial year</td>
<td>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</td>
</tr>
<tr>
<td><strong>Memorandum information</strong></td>
<td></td>
</tr>
<tr>
<td>Unit cost per occupied bed day</td>
<td>This covers admitted patient care on an occupied bed day basis covering ordinary elective and non-elective activity, including leave days.</td>
</tr>
<tr>
<td>Number of cluster days in admitted patient care</td>
<td></td>
</tr>
<tr>
<td>Field</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Unit cost per non-admitted cluster day</td>
<td>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 patient 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.</td>
</tr>
<tr>
<td>Number of cluster days in other settings</td>
<td></td>
</tr>
<tr>
<td>Total number of completed cluster review periods</td>
<td>Total number of review periods in each cluster. If a patient has been allocated to a cluster more than once during the year, each separate time should be counted. A reassessment resulting in the patient remaining in the same cluster does result in a new review period. All review periods which complete during the year should be counted. Include review periods that started in the previous year and completed in the current year. Exclude review periods that started in the current year, but will not complete until next year.</td>
</tr>
<tr>
<td>Average review period (days)</td>
<td>Average length of a cluster review period. This is the average interval between review dates for each patient 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.</td>
</tr>
</tbody>
</table>

**Initial assessments (service code MHCCIA)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit cost per initial assessment</td>
<td>This covers the costs and activity associated with initial assessments of patients, which helps clinicians allocate them to clusters. Initial assessment and clustering of patients can require significant professional resource, and are therefore identified separately rather than included as a support cost for patients who are clustered.</td>
</tr>
<tr>
<td>Number of initial assessments</td>
<td></td>
</tr>
</tbody>
</table>

**Days in the cluster**

418. The count of days in the cluster begins from the day the patient is allocated to 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.
419. 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, which states that the leave beds should be excluded to the extent that this ensures 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.

420. A significant number of providers have been unable to include the costs of community teams’ contact with inpatients in the inpatient quantum for clusters, and this has given rise to inconsistencies in the reported costs per inpatient days. To restore consistency between providers, all providers should now include the costs of community teams’ contacts with inpatients within the non-admitted cluster costs. As more providers move to PLICS it should be possible to identify this amount accurately and include it in the inpatient quantum in future collections.

421. 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 providers must provide costs for the full period of care in the financial year. A review period of 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.

422. Table 29 describes a patient who changes cluster. The patient is assessed and spends 28 days in Cluster 14 at a cost of £10,000. They are reviewed and reallocated 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, they 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 29: Patient change of cluster

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

423. Table 30 describes a patient who is assessed multiple times in-year within a cluster. The patient is allocated to 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 30: Multiple assessment of patient

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Total cost</th>
<th>Number of cluster days within the costing period</th>
<th>Unit cost per day per cluster</th>
<th>Total number of service review periods</th>
<th>Average review period (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>£31,000</td>
<td>28+26+8=62</td>
<td>£500</td>
<td>2</td>
<td>27</td>
</tr>
</tbody>
</table>

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

**Improving access to psychological therapies (IAPT)**

425. Since April 2015, all providers have been required to complete the IAPT minimum dataset, which includes allocating a mental health cluster to each IAPT patient in treatment. The currency for IAPT clusters is cost per completed episode. The IAPT collection will continue to be on a separate sheet to the main mental health cluster costs because IAPT services are distinct from other
mental health services and are, in some areas, delivered by different organisations.

426. All IAPT activity recorded through the IAPT minimum dataset should be reported on the IAPT mental health cluster worksheet (MHCCIAPT) and not within the main mental health clusters worksheet.

427. The mental health clusters used for the IAPT collection are the same clusters as the main mental health clusters and have the same definitions.

428. Similar to the main mental health cluster collection, separate costs will be collected for the initial assessment of a patient before acceptance into services and the costs of treatment by cluster. The definition of the initial assessment period is the same as for the main collection.

429. All costs that occur in the financial year must be reported, regardless of whether they relate to patients whose episodes have not started or have not been completed within the financial year.

430. Table 31 summarises the data we will collect for IAPT services.

**Table 31: IAPT care cluster worksheets**

<table>
<thead>
<tr>
<th>Field</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster costs (service code IAPTMHCC)</td>
<td></td>
</tr>
<tr>
<td>Unit cost per completed episode</td>
<td>The average unit cost of providing treatment to patients on the cluster (including the costs of episodes either not started or not completed in the financial year).</td>
</tr>
<tr>
<td>Total number of completed episodes</td>
<td>The total number of episodes of care completed (closed) during the financial year.</td>
</tr>
<tr>
<td><strong>Memorandum information</strong></td>
<td></td>
</tr>
<tr>
<td>Number of contacts – high intensity</td>
<td>The total number of high intensity contacts provided to patients on the cluster (including the contacts relating to episodes either not started, or not completed in the financial year). The definition of high intensity/low intensity contacts is taken from the IAPT minimum dataset. (High intensity – therapy types 40 to 51).</td>
</tr>
</tbody>
</table>
### Field

<table>
<thead>
<tr>
<th>Number of contacts – low intensity</th>
<th>The total number of low intensity contacts provided to patients on the cluster (including the contacts relating to episodes either not started, or not completed in the financial year). The definition of high intensity/low intensity contacts is taken from the IAPT minimum dataset (low intensity – therapy types 20 to 29).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of cluster days</td>
<td>The total number of days spent in IAPT care clusters completed (closed) during the financial year.</td>
</tr>
<tr>
<td>Average length of episode</td>
<td>The average length of episode in days from first cluster to discharge.</td>
</tr>
<tr>
<td>Average number of contacts per episode</td>
<td>The average number of contacts in each episode.</td>
</tr>
</tbody>
</table>

#### Initial assessments (service code IAPTMHCCIA)

<table>
<thead>
<tr>
<th>Unit cost per initial assessment</th>
<th>This covers the costs and activity associated with initial assessments of patients, which helps clinicians to allocate them to clusters. Initial assessment and clustering of patients can require significant professional resource, and are therefore identified separately rather than included as a support cost for patients who are clustered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of initial assessments</td>
<td></td>
</tr>
</tbody>
</table>

431. The total number of completed episodes is those episodes where the patient has been discharged during the financial year, including episodes started in the previous financial year.

432. The number of contacts relates to contacts with the patient only – either face-to-face or by telephone where appropriate. (A telephone contact must replace a face-to-face contact and not simply be a call to remind a patient of an appointment or change venue, etc.) Where a patient attends a group, each patient will count a contact for that group session. Where two staff members run a group, each patient will count two contacts for that group session. Only contacts with staff members funded by the NHS should be included in the total number of contacts. Where contacts are with social services/voluntary sector staff whose costs are not within the reference costs quantum, these contacts should not be included in the total.
433. The method for calculating the average length of an episode is the same as that for calculating the average time in a cluster. For a completed episode that began in the previous financial year, this will include the number of days in the cluster in the previous financial year as well as those in the current financial year. We are aware that the clustering of IAPT only became mandatory in April 2015; therefore, unless you know the number of days in the previous year, this IAPT episode should start from April 2015.

434. It is not anticipated that the IAPT cluster costs will include any inpatient costs. Where a patient under the care of IAPT services requires an episode of inpatient care, this will start a separate episode of care in the main mental health clusters for working age adults and older adults. If the patient is discharged from IAPT services into the care of a ward or secondary care team, this will end the IAPT episode of care. If the patient is subsequently discharged back to the care of the IAPT team, this will start a new episode of care in IAPT.

435. Where a patient transitions from IAPT into the main mental health services and vice versa, this will initiate an initial assessment in the receiving service.

436. NHS England will continue to work with the trusts submitting this data to try to improve the quality for the 2018 collection, until the data is consistent it will not form part of the reference costs Index.

437. We are aware that some providers are unable to accurately cost the initial assessments for IAPT and it is also difficult to record movement between IAPT clusters. Please record this information to the best standard that you are able.

438. It is important that we maintain the contact information, so please ensure you still accurately record that on the new MHCCIAPT tab. You should also ensure that you always record a unit cost for your activity.

**Child and adolescent mental health services**

439. Child and adolescent mental health services (CAMHS) should be reported in the following settings:

- ordinary elective and non-elective admissions on an occupied bed day basis
- day-care facilities on a patient day basis
- outpatient attendances
- community contacts.
440. There are also subcategories for:

- CAMHS, admitted patients, psychiatric intensive care unit
- CAMHS, community contacts, crisis resolution home treatment.

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

**Drug and alcohol services**

442. Drug and alcohol services are provided for patients who do not have a significant mental health need. These services 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 these settings:

- ordinary elective and non-elective admissions on an occupied bed day basis
- outpatient attendances
- community contacts.

**Specialist mental health services**

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

- adult specialist eating disorder services
- child and adolescent eating disorder services
- gender identity disorder services
- mental health service for deaf children and adolescents
- mental health services for veterans
- specialised services for Asperger syndrome and autism spectrum disorder (all ages)
- specialist mental health services for deaf adults
- specialist perinatal mental health services (inpatient mother and baby units and linked outreach teams)
- other specialist mental health inpatient services.

444. These services should be reported in these settings:
- ordinary elective and non-elective admissions on an occupied bed day basis
- outpatient attendance
- community contacts.

**Settings for non-cluster activity**

**Ordinary elective and non-elective admissions**

445. For ordinary elective and non-elective admissions, 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%.

446. Providers 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.

447. 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 misleading effect of diluting the unit costs.

448. Costs and activity for mental health services provided in day-care facilities\(^91\) should be submitted on the same basis as for other patients using these facilities.

449. 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.

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\(^91\) [www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?shownav=1](www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?shownav=1)
Outpatient attendances

450. Costs and activity should be reported for attendances and non face-to-face contacts. Where consultants have a clinical caseload within a specialist team, eg criminal justice liaison team, the costs and activity should be reported against the specialist team currencies. Where consultants do not have a clinical caseload within a specialist team, costs and activity should be reported in an outpatient or community setting.

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

- 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
- otherwise, it should be reported in a community setting, eg a home or domiciliary visit, or a visit to a single client in a residential home.

452. Primary consultations, eg 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.

453. Payments for domiciliary visits are now only made in limited circumstances, or to consultants who have chosen to retain the old consultant contract (Section 12(2) 2003\textsuperscript{92}). The distinction to be made for reference costs is between:

- a patient seeing a consultant in a clinic, which should be categorised as an outpatient attendance
- a consultant seeing a patient at home, which should be categorised as a community contact.

\textsuperscript{92} http://www.nhsemployers.org/~/media/Employers/Documents/Pay\%20and\%20reward/Consultant_Contract_V9_Revised_Terms_and_Conditions_300813_bt.pdf
Community contacts

454. 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 (CMHTs). CMHTs are teams of variable sizes and combine staff from qualified and unqualified disciplines including social workers, community mental health nurses, occupational therapists, psychiatrists, psychologists, counsellors and community support workers (eg home helps).

455. It is rare for patients to meet more than one discipline (ie qualified professional staff group within each CMHT) at a time. When this does occur, the attendance should be recorded as two separate contacts for reference costs purposes.

456. Figure 7 describes this process.

**Figure 7: Reporting patient contacts with multidisciplinary community mental health teams**

<table>
<thead>
<tr>
<th>Discipline meeting</th>
<th>No of patients</th>
<th>Professionals</th>
<th>Report as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discipline A</td>
<td>1 Patient</td>
<td>Same discipline 1 Professional</td>
<td>1 patient contact</td>
</tr>
<tr>
<td>Discipline A</td>
<td>1 Patient</td>
<td>Same discipline 2 Professionals</td>
<td>1 patient contact</td>
</tr>
<tr>
<td>Discipline A</td>
<td>1 Patient</td>
<td>Same discipline 2 Professionals</td>
<td>2 patient contacts</td>
</tr>
<tr>
<td>Discipline A</td>
<td>1 Patient</td>
<td>Different discipline 2 Professionals</td>
<td>2 patient contacts</td>
</tr>
<tr>
<td>Discipline B</td>
<td>1 Patient</td>
<td>Different discipline 2 Professionals</td>
<td>4 patient contacts</td>
</tr>
</tbody>
</table>

457. 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 8).
458. Where CMHTs include social workers funded by social services, as well as 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**

459. Most cost and activity data for services undertaken by mental health specialist teams (MHSTs), using currencies based on the annual national survey of investment in adult mental health services, 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
- psychosexual services
- prison health
- other mental health specialist teams.

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

**Adult forensic and secure mental health services**

461. Secure mental health inpatient services costs are collected in two ways – by cost per assessment and secondly by occupied bed day for each cluster and pathway combination.

---

462. Pathway and cluster information has been collected centrally through CQUIN since 2012/13 and the NHS England contract since 2013/14 on admitted and reviewed patients.

463. The currencies of adult forensic mental health services are based on both:

- clusters developed for working-age adults and older people (Table 27)
- the five pathways (Table 32).

**Table 32: Five pathways**

<table>
<thead>
<tr>
<th>No</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Treatment responsive</td>
</tr>
<tr>
<td>2</td>
<td>Treatment-resistant challenging behaviours</td>
</tr>
<tr>
<td>3</td>
<td>Treatment-resistant continuing forensic care</td>
</tr>
<tr>
<td>4</td>
<td>Prison transfer: personality disorder</td>
</tr>
<tr>
<td>5</td>
<td>Personality disorder co-morbid</td>
</tr>
</tbody>
</table>

464. NHS England has developed a cluster and pathway combination matrix. This matrix forms the proposed currencies for submission of costs.

465. Templates have been designed to capture the data consistently for all admitted patient care security levels broken down into 18 currency groupings:

- one initial assessment currency (this relates to the period – normally 12 weeks – at the beginning of the patient’s care when the patient will be allocated a cluster and a pathway); costs should be submitted **per initial assessment**
- 16 dominant cluster and pathway combination currencies; costs should be submitted **per occupied bed day**
- one ‘other’ currency for those clusters and pathways which do not fit into the dominant 16 combination currencies.
<table>
<thead>
<tr>
<th>Dominant pathway</th>
<th>Dominant cluster</th>
<th>Proposed code for each currency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>IASS</td>
<td>Initial assessment period (normally 12 weeks)</td>
</tr>
<tr>
<td>1</td>
<td>10</td>
<td>110</td>
<td>Treatment – shorter term – first episode in psychosis (medium/high risk)</td>
</tr>
<tr>
<td>1</td>
<td>11</td>
<td>111</td>
<td>Treatment – shorter term – recurrent psychosis (low symptoms, medium/high risk)</td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>112</td>
<td>Treatment – shorter term – recurrent psychosis (high disability, medium/high risk)</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>211</td>
<td>Treatment – longer term – ongoing psychosis (low symptoms, low/medium risk)</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>212</td>
<td>Treatment – longer term – ongoing psychosis (high disability, low/medium risk)</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>213</td>
<td>Treatment – longer term – ongoing psychosis (high symptoms and disability, low/medium risk)</td>
</tr>
<tr>
<td>2</td>
<td>17</td>
<td>217</td>
<td>Treatment – longer term – psychosis and affective disorder (difficult to engage, low/medium risk)</td>
</tr>
<tr>
<td>3</td>
<td>11</td>
<td>311</td>
<td>Treatment – longer term – ongoing psychosis (low symptoms, medium/high risk)</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>312</td>
<td>Treatment – longer term – ongoing psychosis (high disability, medium/high risk)</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>313</td>
<td>Treatment – longer term – ongoing psychosis (high symptoms and disability, medium/high risk)</td>
</tr>
<tr>
<td>Dominant pathway</td>
<td>Dominant cluster</td>
<td>Proposed code for each currency</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------</td>
<td>---------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>314</td>
<td>Treatment – longer term – psychotic crisis (medium/high risk)</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>316</td>
<td>Treatment – longer term – dual diagnosis (medium/high risk)</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
<td>317</td>
<td>Treatment – longer term – psychosis and affective disorder (difficult to engage, medium/high risk)</td>
</tr>
<tr>
<td>4</td>
<td>8b</td>
<td>48b</td>
<td>Personality disorder – non-psychotic (medium/high risk, prison transfer)</td>
</tr>
<tr>
<td>5</td>
<td>8</td>
<td>58</td>
<td>Personality disorder and psychosis (medium/high risk)</td>
</tr>
<tr>
<td>5</td>
<td>8b</td>
<td>58b</td>
<td>Personality disorder non-psychotic (medium/high risk)</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>OTH</td>
<td>Patients with a cluster and pathway combinations not covered</td>
</tr>
</tbody>
</table>

466. Since 1 April 2017 providers of these services must collect cluster-pathway data to MHSDS v2.0, which is held by NHS Digital. In addition to this requirement, it remains a requirement as set out in contracts held between NHS England Specialist Commissioning and providers.

**Possible changes for 2019**

See Section
Please note: This document was updated in April 2018 to clarify the board assurance requirements (paragraphs 47 and 48).

467. 1: Introduction paragraph 17 for possible changes to the collection for mental health services in 2019.
16: Community services

Introduction

468. This section covers:

- allied health professionals
  - dieticians
  - occupational therapists
  - physiotherapists
  - podiatrists
  - speech and language therapists
  - other therapists

- audiology

- day-care facilities

- health visiting and midwifery
  - health visitors
  - midwives
  - parentcraft

- intermediate care
  - crisis response services
  - home-based services
  - bed-based services

- medical and dental services
  - community dental
  - community paediatric

- nursing
  - specialist nursing
  - district nurses
  - nursing services for children
  - school-based children’s health services

- wheelchair services

- community rehabilitation services.
469. One of the challenges for reference costs for community services has been the lack of a standard minimum dataset and detailed service descriptions for most services commonly classified as community services. The introduction of the Community Information Data Set (CIDS)\(^4\) for local implementation from April 2012 has introduced some conformity of recording and marks a significant step forward.

470. In an attempt to further overcome some of the challenges of costing community services, NHS Improvement has developed new costing standards for community services. These will be used as part of the pilot PLICS collection later this year. Additionally progress is being made on the new national community services dataset.

471. Recognising that not all community providers have fully automated systems, providers may use appropriate sample data to ascertain annual activity when reporting information in this section. There is no minimum sample time stipulated in reference costs but the sample should reflect annual activity in a service area. Where this is not feasible, providers may use informed clinical estimates, retaining evidence of the data source.

472. 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 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.

473. There is no information standard defining the difference between an outpatient attendance and a community care contact. Providers 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

\(^4\) www.ic.nhs.uk/comminfodataset
treated as an outpatient attendance and reported in Section 9: Outpatient services.

474. As community 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 correct costing of services provided and not the funding stream.

475. 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 wards in acute hospitals as well as outside such settings to provide continuity of care to patients.

Definitions

476. Unless otherwise stated for a particular service (eg wheelchair services), the activity measure used to derive a unit cost for all community services is the number of care contacts\(^95\) 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 a support cost.

477. This should include all face-to-face contacts with the patient, or a proxy such as a relative or carer (eg the parent of a young child), where this is in place of a contact with the patient. Only activity that entails contact with the patient or proxy should be included.

478. 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.

479. Only non face-to-face contacts\(^96\) 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 a patient of results are excluded.

\(^95\) [www.datadictionary.nhs.uk/data_dictionary/classes/c/care_contact_de.asp?shownav=1](www.datadictionary.nhs.uk/data_dictionary/classes/c/care_contact_de.asp?shownav=1)

\(^96\) [www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1](www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1)
480. Contacts about the patient but not involving the patient or their proxy should not be recorded as a care contact.

481. From 2014/15 the Department of Health changed the activity measure for group contacts so that it was consistent with the mental health collection.

482. The activity measure for group sessions is therefore the number of patients in the group. If two clinicians deliver a group session for 10 patients, each clinician will record 10 contacts for that group (total 20 contacts).

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

Allied health professionals

484. Reference costs in 2017/18 will cover the following allied health professionals (AHPs).\(^97\)

- dieticians
- occupational therapists
- physiotherapists
- podiatrists
- speech and language therapists
- other therapists (including orthoptists).

485. The ‘other therapist’ currency covers other care professional staff groups defined in the Data Dictionary: namely art therapist, drama therapist, music therapist, and orthoptists. It also covers therapists in complementary or alternative medicine where these services are provided discretely.

486. Therapist services are further subdivided into:

- adult one-to-one
- adult group (unit of activity = number of patients attending the group)

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\(^{97}\) [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)
- child one-to-one
- child group (unit of activity = number of patients attending the groups).

487. The currencies for podiatry services are described in Table 34.

**Table 34: Community podiatry currencies**

<table>
<thead>
<tr>
<th>Currency</th>
<th>Description</th>
<th>Activity measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1, General podiatry</td>
<td>Covers patients with low and medium levels of foot health need, in the absence of complicating disease such as diabetes(^{98}) or rheumatoid arthritis(^{99}) where foot health is identified in NICE guidelines as at risk. It includes painful nail pathologies, dermatological conditions, corns, calluses and fissures, heel pain and metatarsalgia, basic vascular assessments, falls prevention advice and foot health education.</td>
<td>Care contact</td>
</tr>
<tr>
<td>Tier 2, Minor surgery</td>
<td>Includes nail surgery procedures(^{100}) to remove part of the nail or the whole nail to correct ingrowing toenails, or steroid injections to the foot or ankle, performed in community settings by podiatrists.</td>
<td>Procedure</td>
</tr>
<tr>
<td>Tier 3, Complex foot disease</td>
<td>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.</td>
<td>Care contact</td>
</tr>
<tr>
<td>Specialist care 1</td>
<td>Clinical debridement using hydrojet devices and topical negative pressure wound management for complex foot wounds.</td>
<td>Care contact</td>
</tr>
<tr>
<td>Specialist care 2</td>
<td>Advanced vascular assessments. Specialist diagnostics are increasingly used by advanced vascular podiatrists to assess</td>
<td>Care contact</td>
</tr>
</tbody>
</table>

98  [www.nice.org.uk/CG10](http://www.nice.org.uk/CG10)
99  [www.nice.org.uk/CG79](http://www.nice.org.uk/CG79)
100 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.
The table below shows the activity measures for different currencies:

<table>
<thead>
<tr>
<th>Currency</th>
<th>Description</th>
<th>Activity measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the whole limb for risk factors for cardiovascular disease, and incur costs that are significantly different to core podiatry.</td>
<td></td>
</tr>
<tr>
<td>Other non-core podiatry</td>
<td>Any other podiatry services provided in community settings and not described above, including podiatric surgery, complex biomechanics, forensic podiatry.</td>
<td>Care contact</td>
</tr>
</tbody>
</table>

488. 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.

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

**Audiology**

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

491. There are three service codes for audiology in the workbook:

- 254: paediatric audiological medicine
- 310: audiological medicine
- 840: audiology.

**Assessment**

492. The assessment HRG currencies are:

- CA37A: Audiometry or hearing assessment, 19 years and over
- CA37B: Audiometry or hearing assessment, between 5 and 18 years
- CA37C: Audiometry or hearing assessment, 4 years and under
- CA43Z: Balance assessment.

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

- U241: Pure tone audiometry
- U242: Balance assessment
- U243: Hearing assessment
- U248: Other specified diagnostic audiology
- U249: Unspecified diagnostic audiology.

494. Providers should report these costs as procedures in outpatients, as described in Section 9: Outpatient services.

495. The unit cost is per hearing assessment.

**Fitting**

496. The fitting aid currencies are:

- fitting of hearing aid: adult
- fitting of hearing aid: child, commissioned by CCGs
- fitting of hearing aid: child, specialist audiology services commissioned by NHS England
- fitting of hearing aid or device for tinnitus.

497. The unit cost is per fitting.

**Hearing aid**

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

499. The hearing aid currencies are:

- adult hearing aid fitted under an any qualified provider (AQP) contract
- adult hearing aid fitted under a non-AQP contract
- child hearing aid.

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

501. 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

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

- follow-up, adult, face-to-face
- follow-up, child, face-to-face
- follow-up, non face-to-face (eg telephone or postal questionnaire).

Aftercare

503. The aftercare currency covers costs associated with:

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

504. Separate currencies 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.

505. The aftercare currencies are:

- aftercare
- maintenance and programming, BAHA
- maintenance and programming, cochlear implant.

506. The unit cost is per episode of aftercare.

Newborn hearing screening

507. Providers 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

508. As well as hearing tests, a range of other rehabilitative services are provided through audiology departments, eg 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:

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

509. The following HRGs relating to audiology are captured using codes within the admitted patient care or outpatient CDS, and should be reported in Section 8: Admitted patient care or Section 9: Outpatient services and not here:

- CA38A: Evoked potential recording, 19 years and over
- CA38B: Evoked potential recording, 18 years and under
- CA39Z: Fixture for bone-anchored hearing aids
- CA40Z: Fitting of bone-anchored hearing aids
- CA41Z: Bilateral cochlear implants
- CA42Z: Unilateral cochlear implant.

Day care facilities

510. Day care facilities\(^{102}\) catering for elderly, stroke, mental health, and other patients are included in reference costs. Facilities catering primarily for patients with learning disabilities are excluded, as are all services for these patients.

511. The unit cost is per patient day.

512. Patients often attend these facilities for a number of days each week and the number of attendances will vary depending on the patient’s condition. Generally, the number of spaces available in a day care facility is fixed: eg 20 patients each

\(^{102}\) [www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?shownav=1](www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?shownav=1)
day over five days gives 100 patient days, or one patient attending one day per week for 20 weeks gives 20 patient days. Convert part-day attendees to patient days: eg a morning-only attendance equals 0.5 patient days.

Health visitors and midwifery

Health visitors

513. 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:

- antenatal review (1 hour)
- new baby review (2 hours)
- 6 to 8 weeks check (1 hour)
- 1 year review (1 hour)
- 2 to 2.5 years review (2 hours)
- other clinical interventions to provide parenting support on specific issues, eg behaviour management, breast feeding, postnatal depression, toilet training and weaning (30 minutes).

514. An extra 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, 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-years settings).

515. We are continuing a separate currency for Family Nurse Partnership (FNP) programmes delivered by family nurses, because we recognise they are more resource intensive.

516. Providers should continue to report immunisations separately at full cost (including travel costs), on the same basis as school-based children’s services.

Midwives

517. Community midwifery services have been divided into:

- antenatal visits
- home births
- postnatal visits.

518. Home births do not have a specific line on the community health services sheet in the collection workbook but should be split over the various delivery codes on the sheet.

Parentcraft

519. Parentcraft classes are multidisciplinary and may include health visitors, community midwives and other healthcare professionals. They should be reported as group sessions. The unit of activity will be the number of patients attending the groups.

Intermediate care

520. Intermediate care is a range of integrated services for adults aged 19 and over. The services 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.

521. 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.

522. Services are predominantly provided by health professionals in multidisciplinary 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.

523. 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

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periods of transition, and incorporating a wide range of different services. The services that might contribute to the intermediate care function include:

- 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
- 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
- supported discharge or support in a patient’s own home to prevent admission, with nursing and/or therapeutic support and community equipment where necessary, to allow rehabilitation and recovery at home
- day rehabilitation for a limited period in a day hospital or day centre, possibly with other forms of intermediate care support.

524. The key client groups for these currencies are older people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential or nursing care homes. Intermediate care may also be provided for older people with mental health needs, such as 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 15: Mental health services, otherwise the costs and activity should be reported here.

525. Table 35 below describes the currencies for intermediate care.
<table>
<thead>
<tr>
<th>Currency</th>
<th>Setting</th>
<th>Aim</th>
<th>Period</th>
<th>Activity measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crisis response services</strong></td>
<td>Community-based services provided to patients in their own home or a care home</td>
<td>Assessment and short-term interventions to avoid hospital admission</td>
<td>Interventions for most patients 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.</td>
<td>Unit cost per patient</td>
</tr>
<tr>
<td><strong>Home-based services</strong></td>
<td>Community-based services provided to patients in their own home or a care home</td>
<td>Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living</td>
<td>Interventions for most patients will last up to six weeks (though there will be individual exceptions).</td>
<td>Unit cost per care contact</td>
</tr>
<tr>
<td><strong>Bed-based services</strong></td>
<td>Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, local authority facility or other bed-based setting</td>
<td>Prevention of unnecessary acute hospital admissions and premature admissions to long-term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital</td>
<td>Interventions for most patients will last up to six weeks (though there will be individual exceptions).</td>
<td>Unit cost per occupied bed day</td>
</tr>
</tbody>
</table>
526. These currencies include:

- all admission avoidance schemes whatever their location, which should be included in crisis response (for example, teams based in an A&E department to identify patients for whom an admission could be avoided)
- early supported discharge in the home, which should be included in home-based services, with the exception of condition-specific schemes that are excluded in accordance with paragraph 527 below.

527. These currencies exclude:

- 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 19: Services excluded from the national cost collection.**
- Reablement services, which are community-based services designed to help people recover the skills and confidence to live at home, and are predominantly provided by social care professionals in MDTs. Costs and activity should be excluded as set out in the bold text above.
- Intermediate care delivered to children aged under 18. Costs and activity should be excluded as set out in the bold text above.
- 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.
- Single condition rehabilitation (eg stroke). Costs and activity should be reported against the unbundled rehabilitation HRGs in paragraph 324 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.
- 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 15: Mental health services.
- General community hospital beds not designated as intermediate care. Costs and activity should be reported as specified in paragraph 472.
• 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 533.

528. We are not introducing casemix-adjusted currencies because of the very wide range of underlying medical conditions present within intermediate care patients.

529. 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 19: Services excluded from the national cost collection), but providers 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

530. Community dental services generally cover 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:

• **Community dental services**: community dentistry for patients who are unable to access NHS dentistry locally, 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.

• **General dental services**: some community providers provide a full range of NHS dental treatment for patients in a high street setting. The unit cost is per attendance.

• **Emergency dental services**: also known as dental access services. The unit cost is per attendance.

531. In each case the unit is per care contact – regardless of the units of dental activity (UDAs) that may be counted in that contact.
Community paediatric

532. Community paediatric services should be reported in Section 9: Outpatient services under TFC 290 and not here.

Nursing

Specialist nursing services

533. Specialist nursing services are disaggregated by the bands in Table 36, split further by adult or child and face-to-face or non face-to-face.

Table 36: Specialist nursing service bands

<table>
<thead>
<tr>
<th>National code</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>N06</td>
<td>Active case management (community matrons)</td>
<td></td>
</tr>
<tr>
<td>N07</td>
<td>Arthritis nursing/liaison</td>
<td></td>
</tr>
<tr>
<td>N08</td>
<td>Asthma and respiratory nursing/liaison</td>
<td></td>
</tr>
<tr>
<td>N09</td>
<td>Breast care nursing/liaison</td>
<td></td>
</tr>
<tr>
<td>N10</td>
<td>Cancer related</td>
<td></td>
</tr>
<tr>
<td>N11</td>
<td>Cardiac nursing/liaison</td>
<td></td>
</tr>
<tr>
<td>N12</td>
<td>Children's services</td>
<td>See paragraph 516</td>
</tr>
<tr>
<td>N14</td>
<td>Continence services</td>
<td>Exclude costs relating to patients in regular receipt of supplies (eg continence pads, stoma bags) which should be reported against home delivery of drugs and supplies in Section 19: Services excluded from the national cost collection</td>
</tr>
<tr>
<td>N15</td>
<td>Diabetic nursing/liaison</td>
<td></td>
</tr>
<tr>
<td>N16</td>
<td>Enteral feeding nursing services</td>
<td></td>
</tr>
<tr>
<td>N17</td>
<td>Haemophilia nursing services</td>
<td></td>
</tr>
<tr>
<td>National code</td>
<td>Description</td>
<td>Comment</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>N18</td>
<td>HIV/AIDS nursing services</td>
<td>Includes follow up of HIV care, psychosocial support, treatment support for individuals starting or switching therapy, etc</td>
</tr>
<tr>
<td>N19</td>
<td>Infectious diseases</td>
<td></td>
</tr>
<tr>
<td>N20</td>
<td>Intensive care nursing</td>
<td></td>
</tr>
<tr>
<td>N21</td>
<td>Palliative/respite care</td>
<td></td>
</tr>
<tr>
<td>N22</td>
<td>Parkinson's and Alzheimer's nursing/liaison</td>
<td></td>
</tr>
<tr>
<td>N24</td>
<td>Stoma care services</td>
<td>See comment under N14/Continence services</td>
</tr>
<tr>
<td>N25</td>
<td>Tissue viability nursing/liaison</td>
<td></td>
</tr>
<tr>
<td>N26</td>
<td>Transplantation patients nursing service</td>
<td>Includes patients on pre- and post-transplantation programmes</td>
</tr>
<tr>
<td>N27</td>
<td>Treatment room nursing services</td>
<td>To be used for nursing staff based in GP surgeries</td>
</tr>
<tr>
<td>N28</td>
<td>Tuberculosis specialist nursing</td>
<td></td>
</tr>
<tr>
<td>N29</td>
<td>Other specialist nursing</td>
<td>eg sickle cell</td>
</tr>
</tbody>
</table>

534. Specialist nursing: community cystic fibrosis should be included in the year-of-care currencies for cystic fibrosis (Section 18: Cystic fibrosis).

**Nursing services for children**

535. As well as specialist nursing services, the NHS provides a range of other nursing services for children, including:

- vulnerable children support, including child protection and family therapy
- development services for children, including psychology
- paediatric liaison
- other child nursing services not included in specialist nursing and school-based child health services, including looked-after children nurses.
536. These services should be reported as one composite group using total community contacts in the reference costs year as the activity measure.

537. The following should be noted for child protection services, which are separate to services performed by community paediatricians:

- In general, the cost of child protection is a support cost 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.
- 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.
- Where the service is advisory to other elements of healthcare, and there is no contact with children, costs should be apportioned between the service areas that receive advice.
- For consistency with other reference cost definitions, activity relating to meetings about the patient are not counted for reference costs. The costs of these meetings should be included as a support cost and apportioned as appropriate.

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

**District nursing services**

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

**School-based children's health services**

540. 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 who are school-based and providing health services. While having significant levels of nursing input, they also have input from community paediatricians. For reference costs, school-based services have been divided into:

- Core services, including school entry review and year 6 obesity monitoring, further subdivided into:
  - one-to-one
– group single professional
– group multiprofessional (using the same definition of multiprofessional in paragraph 159).

- 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:
  - one-to-one
  - group single professional
  - group multiprofessional.

- 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. Vaccination programmes have changed over the past few years, so it is important to appreciate that the costs collected are average costs of at least four different vaccination programmes (Fluenz, Men ACWY, School Leaver Booster and HPV). These can range in cost from less than £10 to over £30 each, but the collection is an average cost per vaccination.

- Special schools nursing. This category was new for the 2014/15 collection, and the unit of activity is a patient contact.

541. 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**

542. In 2013/14 we introduced needs-based currencies for non-complex wheelchair services covering assessment, equipment, review and repair and maintenance (Table 37 below). This was based on a report commissioned by the Department of Health from Deloitte to develop an initial non-mandatory tariff for these services. These currencies do not cover specialised complex wheelchair services commissioned by NHS England, which should be separately reported on the basis of unit cost per registered user.

543. The currencies themselves make no distinction between adults and children. However, 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).
544. Following discussions with NHS England’s pricing team about the costs collected for wheelchair services, Table 37 below has been produced to better describe the currencies and examples of the activity that should appear in each HRG.
<table>
<thead>
<tr>
<th>Code</th>
<th>Unit</th>
<th>Activity</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>WC01</td>
<td>Per episode of care</td>
<td>Low need – assessment</td>
<td>Limited need allocation of clinical time. Most of the activity expected to fall into this category.</td>
<td>Occasional users of wheelchair with relatively simple needs that can be readily met. Do not have postural or special seating needs. Physical condition is stable, or not expected to change significantly. Assessment does not typically require specialist staff (generally self-assessment or telephone triage supported by health/social care professional or technician). Limited (or no) requirement for continued follow up/review.</td>
</tr>
<tr>
<td>WC02</td>
<td></td>
<td>Medium need – assessment</td>
<td>Higher allocation of clinical time including the use of more specialist time.</td>
<td>Daily users of wheelchair, or us for significant periods most days. Have some postural or seating needs. Physical condition may be expected to change (eg weight gain/loss, some degenerative conditions). Comprehensive, holistic assessment by skilled assessor required. Regular follow-up/review.</td>
</tr>
<tr>
<td>Code</td>
<td>Unit</td>
<td>Activity</td>
<td>Definition</td>
<td>Examples</td>
</tr>
<tr>
<td>-------</td>
<td>--------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>WC03</td>
<td></td>
<td>High need – manual assessment</td>
<td>This currency involves a higher allocation of clinical time than the medium currency. This also includes the use of a higher and more specialist skillset of staff.</td>
<td>Permanent users who are fully dependent on their wheelchair for all mobility needs. Physical condition may be expected to change/degenerate over time. Very active users, requiring ultra-lightweight equipment to maintain high level of independence. Initial assessment for all children. Comprehensive, holistic assessment by skilled assessor required. Regular follow-up/review with frequent adjustment required/expected.</td>
</tr>
<tr>
<td>WC04</td>
<td></td>
<td>High need – powered-assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WC05</td>
<td>Per chair issued</td>
<td>Low need – equipment</td>
<td>A basic wheelchair package that includes a standard cushion and one accessory and modification.</td>
<td>Equipment requirements – basic wheelchair (self or attendant propelled). Standard cushion, up to one accessory and up to one modification.</td>
</tr>
<tr>
<td>WC06</td>
<td></td>
<td>Medium need – equipment</td>
<td>A higher allocation of equipment and modifications.</td>
<td>Equipment requirements – configurable, lightweight or modular wheelchair (self or attendant propelled). Low to medium pressure-relieving cushions, basic buggies, up to two accessories and up to two modifications.</td>
</tr>
<tr>
<td>Code</td>
<td>Unit</td>
<td>Activity</td>
<td>Definition</td>
<td>Examples</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------</td>
<td>-------------------------</td>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>WC07</td>
<td></td>
<td>High need – manual</td>
<td>More complex and customised</td>
<td>Equipment requirements – complex manual or powered equipment including tilt-in-place or fixed-frame chairs, seating systems of different chassis, high pressure-relieving cushions, specialist buggies, multiple accessories, multiple and/or complex modifications and needs are met by customised equipment.</td>
</tr>
<tr>
<td>WC08</td>
<td></td>
<td>High need – powered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WC09</td>
<td>Per registered user</td>
<td>All needs – manual</td>
<td>The tariff has assumed that services will be</td>
<td>The unit cost for each chair can be calculated using the total R&amp;M budget against activity for the period. In calculating the average R&amp;M unit cost per chair, use a combination of low, medium and high needs categorisation. This only applies to manual wheelchairs.</td>
</tr>
<tr>
<td>WC10</td>
<td>user per year</td>
<td>repair and maintenance</td>
<td>outsourced to a third party provider and taken</td>
<td></td>
</tr>
<tr>
<td>WC11</td>
<td>Per review</td>
<td>All needs – review</td>
<td>This involves the review of a patient.</td>
<td>This could be planned or via an emergency route when the patient’s condition or equipment changes. A review that results in the patient being provided with additional equipment or modification will incur a separate charge.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Unit</td>
<td>Activity</td>
<td>Definition</td>
<td>Examples</td>
</tr>
<tr>
<td>-------</td>
<td>----------------</td>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>WC12</td>
<td>Per item</td>
<td>All needs – review substantial</td>
<td>A review following a modification/new accessory or resulting in a completely new follow-up assessment if a new wheelchair is required.</td>
<td>All needs – review substantial accessory (a review of existing equipment issued to the service user followed by a minor modification/onward referral to R&amp;M/new accessory (cushion or seat backs). If (as arising from the review) a complete new assessment or new wheelchair is required this will be recorded in the assessment and equipment pathways as a new episode of care.</td>
</tr>
<tr>
<td>WC13</td>
<td>Per review</td>
<td>Specialised complex wheelchair services</td>
<td>More complex and customised</td>
<td>A higher allocation of equipment modifications. Costs per chair not per modification.</td>
</tr>
<tr>
<td>WC14</td>
<td></td>
<td>Equipment, specialist modification without supply</td>
<td>This involves a review of the patient.</td>
<td>A higher allocation of equipment and modifications. Seating systems on different chassis/high pressure relieving cushions/specialist buggies/multiple accessories/multiple and/or complex. Wheelchair not supplied.</td>
</tr>
</tbody>
</table>
Assessment currencies

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

- **Low need**: a limited allocation of clinical time, reflecting the expectation that the assessment needs of most users falling into this category can be met through telephone triage, or review of referral materials provided by a competent referrer.
- **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.
- **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.
- **Review**: a separate currency to incentivise clinical reviews for patients. These extra elements would need to be costed through the other currencies.

546. 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 (see below) due to the potential for different service providers to complete these tasks.

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

Equipment currencies

548. The equipment currencies are based on the delivery of a complete ‘equipment package’ of the wheelchair, 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; eg a basic chair with an enhanced pressure-relieving cushion would be costed at the medium level of complexity.

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

- low
- medium
- high (manual)
- high (power).
550. In addition, a currency is included for the provision of substantive extra accessories, eg 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.

551. Allocation of costs to these currencies should be made on the basis of average costs, reflecting the level of need, for:

- chair
- cushioning
- accessories
- occupational therapy technician or rehabilitation engineering time to perform modifications to the chair and fitting of accessories
- clinical time associated with checking of modifications and handover of equipment.

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

553. In 2014/15 we introduced an extra category for specialist modifications without supply. The equipment currencies above are based on delivery of a complete package of chair plus modifications, but some specialist suppliers modify chairs supplied by another provider. 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**

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

- parts and labour for repair of wheelchairs
- delivery or collection of chairs to or from users
- costs associated with scrapping chairs at the end of their useful lifecycle
- annual planned preventive maintenance for power chair users.

555. The unit cost for the repair and maintenance currencies is per registered user per year.
Single condition community rehabilitation teams

556. This section is for single condition community rehabilitation teams (such as stroke rehab or neuro rehab teams), which are excluded from the intermediate care collection under paragraph 527 above, but do not meet the definitions for unbundled rehabilitation HRGs in paragraph 324.

557. Community rehabilitation teams usually include a number of healthcare professionals providing ongoing care to patients in a community setting. The range of services provided will vary patient by patient, 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.

558. The activity measure is the number of team contacts in a financial year: eg 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, ie that total clinical caseload for that professional relates solely to team activity. Where members of a clinical team also see patients in another capacity (eg 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, eg community speech and language therapy.

559. The collection for community rehabilitation teams will be categorised as one of:

- stroke community rehabilitation teams
- neuro community rehabilitation teams
- other single condition community rehabilitation teams.
17: Ambulance services

Introduction

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

Currencies

561. 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. The four currencies are:

- calls
- hear and treat or refer
- see and treat or refer
- see and treat and convey.

Calls

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

563. This includes 999 calls, calls from other healthcare professionals requesting urgent transport for patients, calls transferred or referred from other services (such as other emergency services, NHS 111, other third parties).

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

565. It excludes calls abandoned before they are answered, patient transport service (PTS) requests, calls under any private or non-NHS contract.

566. The unit cost is the cost per call.

Hear and treat or refer

567. 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.

568. This includes 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, 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 healthcare provider.

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

570. The unit cost is the cost per patient.

See and treat or refer

571. 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. The patient is not taken anywhere.

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

573. It includes incidents where, on arrival at the scene, ambulance trust professionals are unable to locate a patient or incident.

574. It includes incidents despatched by third parties (such as NHS 111 or other emergency services) directly accessing the ambulance control despatch system.

575. The unit cost is the cost per incident.

See and treat and convey

576. 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.
577. Alternative healthcare provider includes any other provider that can accept ambulance patients, such as A&E, minor injury unit, walk-in centre, major trauma centre, independent provider, etc.

578. It includes incidents despatched by third parties (such as NHS 111 or other emergency services) directly accessing the ambulance control despatch system.

579. It excludes PTS and other private or non-NHS contracts.

580. The unit cost is the cost per incident.

Possible changes for 2019

See Section

Please note: This document was updated in April 2018 to clarify the board assurance requirements (paragraphs 47 and 48).

581. 1: Introduction paragraph 26 for possible changes to the collection for ambulance services in 2019.
18: Cystic fibrosis

Introduction

582. This section covers the cystic fibrosis year-of-care currency that adult and paediatric cystic fibrosis centres, and other providers with network care arrangements, should use to report reference costs.

583. There are two models for the delivery of care for children with cystic fibrosis:

- full care delivered entirely by a specialist cystic fibrosis centre
- shared care 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.

584. For the purposes of the reference costs collection, there are two worksheets in the collection workbook for children – one to capture costs and activity from providers delivering 100% care in their capacity as a specialist provider, and one to capture costs and activity from providers delivering care in their capacity as a network provider. Individual providers may provide care under both arrangements.

585. 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.

586. For the purposes of the reference costs collection, there are two worksheets in the collection workbook for adults – one to capture costs and activity from providers delivering 100% of care in their capacity as a specialist provider, and one to capture costs and activity from providers 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 spreadsheet. Individual providers may provide care under both arrangements.

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587. 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.

588. The Cystic Fibrosis Trust\(^{107}\) will inform trusts how each patient will be categorised for the coming year. These bands will be issued in February 2018.

589. To help improve the quality of these year-of-care costs, providers should:

- calculate costs against the 2018 calendar year bands, with no further local adjustment
- ensure the data from network care providers conforms with this banding data before submission
- ensure that all patients are allocated to the appropriate specialist and network care reporting lines
- separate new patients from normal band 2a patients using the reporting lines provided within the submission worksheets year-of-care currencies.

590. 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 band describes an increasingly complex year of care. The bands are described in the Specialised Services National Definitions Set (SSNDS) Definition No10: Cystic Fibrosis Services (all ages) (3rd edition).\(^{108}\)

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

592. Allocations to bands are based on data from the calendar year before the next financial year and are issued each February. The 2017 calendar year bands issued in February 2018 by the Cystic Fibrosis Trust should be used for 2017/18 reference costs.

593. 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

\(^{107}\) [www.cftrust.org.uk/](http://www.cftrust.org.uk/)

\(^{108}\) [www.specialisedservices.nhs.uk/doc/cystic-fibrosis-services-all-ages](http://www.specialisedservices.nhs.uk/doc/cystic-fibrosis-services-all-ages)
disease severity over several years. There will be no movement of patients between bands during any one financial year.

594. The currencies themselves make no distinction between adults and children. However, 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**

595. There are likely to be increases and decreases in the number 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.

596. Newly diagnosed patients and new births will be banded as 2A, which recognises the extra costs associated with diagnosis and treatment of a new patient. For the first year you will need to identify new patients within the cohort of 2A patients and report their costs separately in the submission worksheet. These patients will be banded appropriately by the Cystic Fibrosis Trust in subsequent years, so this adjustment will only be required in the first year.

597. Clinical transition from children’s to adult service or transfer to another centre may take place over 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.

598. In some cases, such as where young people are away at university or patients need care while 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. If a patient requires treatment away from the centre responsible for their care, the responsible centre will be expected to cost this under a provider-to-provider agreement (paragraph 658).
Network and outreach care

599. 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.

600. Specialist centres that 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.

601. Specialist centres, network care providers and outreach clinic providers that 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 also complete the ‘Cystic fibrosis – network care arrangements in place’ worksheet (as illustrated in Table 38).

602. In this case, they should record their own provider’s part year-of-care costs and activity under service code ‘NET’ on the ‘CFNET’ flexible worksheet, broken down by:

- bands
- 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).

603. Specialist centres will be those from which NHS England commissions cystic fibrosis services.
Table 38: Reporting part year-of-care costs for cystic fibrosis under network care arrangements

<table>
<thead>
<tr>
<th>Service name</th>
<th>Currency name</th>
<th>Department code</th>
<th>Service code</th>
<th>Currency code</th>
<th>Part year-of-care cost per patient</th>
<th>Number of patients</th>
<th>Org code of other specialist or network care provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network care</td>
<td>Cystic fibrosis band 1 children 16 years and under</td>
<td>CF</td>
<td>NET</td>
<td>B1C</td>
<td>2,000.00</td>
<td>20</td>
<td>R1A</td>
</tr>
<tr>
<td>Network care</td>
<td>Cystic fibrosis band 1 children 16 years and under</td>
<td>CF</td>
<td>NET</td>
<td>B1C</td>
<td>1,500.00</td>
<td>10</td>
<td>R1C</td>
</tr>
<tr>
<td>Network care</td>
<td>Cystic fibrosis band 1 children 16 years and under</td>
<td>CF</td>
<td>NET</td>
<td>B1C</td>
<td>2,000.00</td>
<td>5</td>
<td>R1D</td>
</tr>
<tr>
<td>Network care</td>
<td>Cystic fibrosis band 1A children 16 years and under</td>
<td>CF</td>
<td>NET</td>
<td>B1AC</td>
<td>2,500.00</td>
<td>10</td>
<td>R1A</td>
</tr>
<tr>
<td>Network care</td>
<td>Cystic fibrosis band 1A children 16 years and under</td>
<td>CF</td>
<td>NET</td>
<td>B1AC</td>
<td>3,000.00</td>
<td>5</td>
<td>R1C</td>
</tr>
<tr>
<td>Network care</td>
<td>Cystic fibrosis band 2 children 16 years and under</td>
<td>CF</td>
<td>NET</td>
<td>B2C</td>
<td>4,000.00</td>
<td>2</td>
<td>R1A</td>
</tr>
</tbody>
</table>

Costing cystic fibrosis

604. The costs submitted against the bands issued in February 2018 should cover all cystic fibrosis related care for the 2017/18 financial year. This includes:

- 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 whether it is 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
A primary diagnosis of cystic fibrosis may also be a useful way to identify cystic fibrosis specific care.

- 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.
- Intravenous antibiotics provided during admitted patient care.
- Annual review investigations.

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

- 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. 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.
- Unrelated care will be assigned to the relevant HRG or TFC, e.g., obstetric care for a pregnant woman with cystic fibrosis; ear, nose, and throat (ENT) outpatient review for nasal polyps. Cystic fibrosis ICD-10 codes are included in HRG complication and co-morbidity lists and recognised in HRG4+ output.
- 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.
- Costs associated with long-term nutritional supplementation via gastrostomy or nasogastric tube feeding remain within primary medical services.
- 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) are not included.
- Costs associated with high cost antifungal drugs that generate an unbundled high cost drug HRG are not included.

[109] www.datadictionary.nhs.uk/web_site_content/supporting_information/main_specialty_and_treatment_function_codes_table.asp?shownav=1
• 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.
• Patient transport services are not included.

606. 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.

607. 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.

**PLICS: Treatment for cystic fibrosis**

608. For PLICS, cystic fibrosis cost and activity must be identified and excluded from APC and OP patient-level extracts. Cystic fibrosis costs must be reported in the reference costs workbook only, as per the guidance above.
19: Services excluded from the national cost collection

609. The national cost collection is 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.

610. The services listed in Table 39 below are excluded from the reference costs workbook and PLICS patient-level extracts because they meet one or more of the following criteria:

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

611. Only these services may be excluded. Their total cost should be excluded using full absorption costing, and recorded on the reconciliation statement.
<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
</table>
| **Ambulance trusts: specified services** | The following services or costs are excluded (ambulance trusts only):  
  - air ambulance service  
  - chemical biological radiological and nuclear costs  
  - decontamination units  
  - emergency bed service  
  - emergency planning  
  - hazardous area response teams  
  - helicopter emergency medical services (part provided by Barts Health NHS Trust)  
  - logistics or courier transport service, eg collecting clinical waste  
  - neonatal transfers (non-ambulance trusts should report the costs of neonatal critical care transportation under HRG XA06Z)  
  - out-of-hours services  
  - patient education  
  - single point of access telephony services  
  No other service, and no other provider type to ambulance trusts, may be excluded in this category without our permission. | These services are not part of the ambulance service currencies for contracting, and no other suitable currency exists.                                                                                                                     |
<p>| <strong>Cystic fibrosis drugs</strong>            | 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.                                                                                                                   | These drug costs are not part of the mandatory cystic fibrosis year-of-care currency.                                                                                           |</p>
<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
</table>
| 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 487), and that are provided during an admitted patient episode or outpatient attendance.  
If you feel an aid or appliance should be excluded from your costs please contact costing@improvement.nhs.uk and we will consider the exclusion case by case. | 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:  
- contraception and sexual health  
- oral health promotion  
- stop-smoking education programme  
- substance misuse  
- weight management  
- other health promotion programme. | We are considering suitable activity measures with a view to collecting unit costs in future reference costs collections.                                                                                                                                                                                             |
<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>High cost devices</td>
<td>Please refer to Annex A – National tariff workbook, worksheet 13a. This lists the high cost devices that should be excluded from the HRG costs, and detailed in the reconciliation. Please note that cochlear prosthesis and consumables for robotic surgery are no longer on this list. <a href="https://improvement.nhs.uk/resources/national-tariff-1719/">https://improvement.nhs.uk/resources/national-tariff-1719/</a></td>
<td>Following the scheme set up by NHS England to procure high cost devices centrally, we need to ensure that the HRG costs either include or exclude the cost of the high cost device. As some providers no longer bear that cost, exclusion of the cost will ensure this is the case.</td>
</tr>
</tbody>
</table>
| Home delivery of drugs and supplies: administration and associated costs | Providers 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, providers should include the administration and associated costs relating to home delivery of drugs and supplies, including:  
  - costs of enrolling patients and managing the home care service  
  - costs of contracting, ordering, invoice matching and payment  
  - nurse support of a non-clinical nature  
  - any other associated administrative costs. | There is currently no national requirement to understand the unit costs of providing this service.                                                                                                                                                                                                   |
| Home delivery of drugs and supplies: drugs, supplies and associated costs | On this line, providers should include the costs of:  
  - drugs, including oxygen or blood products  
  - supplies, eg, continence pads or enteral feeding  
  - delivery of drugs or supplies  
  - any other associated drug or supply costs. | There is currently no national requirement to understand the unit costs of providing this service.                                                                                                                                                                                                   |
<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital travel costs scheme (HTCS)</td>
<td>Scheme offering financial help with the cost of travel to and from hospitals and other NHS centres. 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 a support cost in their reference costs.</td>
<td>Because this scheme makes fixed payments to eligible NHS patients, there is no requirement to understand or benchmark provider unit costs.</td>
</tr>
<tr>
<td>In vitro fertilisation (IVF) drugs</td>
<td>All costs associated with IVF drug regimens (their generic name is gonadotropins) must be excluded from the IVF activity and reported on the drugs and devices sheet within the RECON area of the collection.</td>
<td>This is to better inform the tariff.</td>
</tr>
<tr>
<td>Learning disability services</td>
<td></td>
<td>We will consider whether to include learning disability services in reference costs from 2018/19.</td>
</tr>
<tr>
<td>Local Improvement Finance Trust (LIFT) and private finance initiative (PFI) set-up costs</td>
<td>See paragraph 613</td>
<td>These are one-off costs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
</table>
| Mental health providers: specified services          | The following services delivered by mental health providers:  
- acquired brain injury  
- neuropsychiatry.  
No other service, and no other provider type to mental health providers, may be excluded in this category without our permission.                                                                 | No suitable currencies exist.                                                                                                                                                                                                  |
| Named providers – specified services                  | The following services are excluded:  
- Clinical toxicology service: Guy’s and St Thomas’ NHS Foundation Trust  
- Fixated threat assessment centre: Barnet, Enfield and Haringey Mental Health NHS Trust  
- High secure infectious disease units: Royal Free London NHS Foundation Trust and The Newcastle upon Tyne Hospitals NHS Foundation Trust  
- Low energy proton therapy for ocular oncology: The Clatterbridge Cancer Centre NHS Foundation Trust  
- National Poisons Information Service: The Newcastle upon Tyne Hospitals NHS Foundation Trust  
- National Artificial Eye Service: Blackpool Teaching Hospitals NHS Foundation Trust.  
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. |
<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS continuing healthcare, NHS-funded nursing care and excluded intermediate care for individuals aged 18 or over</td>
<td>NHS continuing healthcare means a package of ongoing care arranged and funded solely by the NHS where the individual has been found to have a ‘primary health need’ as set out in guidance. 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 care provided by a registered nurse for people who live in a care home. This also includes the Electronic Assistive Technology Service (EATS) and augmentative and alternative communication (AAC) services. Excluded intermediate care is those services defined in paragraph 527.</td>
<td>We wish to test the collection of intermediate care services in Section 16: Community services before considering NHS continuing healthcare.</td>
</tr>
<tr>
<td>NHS continuing healthcare, NHS-funded nursing care for children.</td>
<td>NHS continuing healthcare means a package of ongoing care arranged and funded solely by the NHS where the individual has been found to have a ‘primary health need’ as described in guidance. Such care is provided to a 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. NHS-funded nursing care is care provided by a registered nurse for people who live in a care home.</td>
<td>Lack of robust activity data.</td>
</tr>
<tr>
<td>Outsourced activity</td>
<td>Activity that is outsourced to a private provider.</td>
<td>Feedback to NHS Improvement suggests that costing and submitting this activity is becoming increasingly difficult.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient transport services (PTS)</td>
<td>All costs associated with services run by ambulance trusts and other PTS providers offering transportation of patients to and from their place of residence, premises providing NHS healthcare, and/or between NHS healthcare providers for people who have a medical need.</td>
<td>Patient transport services were included in reference costs between 2006/07 and 2009/10, and excluded from 2010/11. Consultation with the sector suggests that collection of this data would be very complex.</td>
</tr>
</tbody>
</table>
| Pooled or unified budgets        | As a general principle, costs and activity are excluded for services jointly provided under pooled or unified budget arrangements with agencies outside the NHS, such as social services, housing, employment, education (eg Sure Start), home equipment loans or community equipment stores. This also includes:  
  - costs relating to advice to non-NHS bodies  
  - vaccination programmes part-funded by GPs or non-NHS providers.  
  Where providers are confident they can separately identify a discrete element of the service that is funded by the NHS, identify the total costs incurred by that service, and have accurate and reflective activity data, they are encouraged to include that service. | Services provided by bodies outside the NHS, such as local government, are outside the scope of reference costs.  
We are aware this is likely to become a bigger issue in future as engagement with other agencies increases. With this in mind, we will discuss it at the community cost collection advisory group (CCAG) 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-hours services. | Primary medical services are subject to separate funding arrangement and are outside the scope of reference costs.                                                                                                           |</p>
<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison health services</td>
<td></td>
<td>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), and we will consider whether other costs and activity should be included in future.</td>
</tr>
<tr>
<td>Screening programmes</td>
<td>National screening programmes</td>
<td>Treatment varies – some national screening programmes are excluded and some are included. See Table 40 below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excluded service</th>
<th>Definition or description</th>
<th>Why is the service excluded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified hosted services</td>
<td>Services hosted in one provider, providing benefit for the patients of other providers. The specified services are:</td>
<td>There is no patient event to which costs can be allocated. The host provider is fully funded, and there is no recharge to other providers.</td>
</tr>
<tr>
<td></td>
<td>• genetic laboratory services – specialist laboratory services that are nationally commissioned and members of the UK Genetic Testing Network (UKGTN); each laboratory carries out rare genetic tests for a large number of hospitals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• intensive care support services – providing transport, advice or other services for critical care patients regionally</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• child health information services (CHIS) – the cost of providing this service should not be allocated to patient care categories, but should be excluded under this category.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No other service may be excluded in this category without our permission.</td>
<td></td>
</tr>
<tr>
<td>Vanguard sites</td>
<td>Costs relating to setting up these sites should be excluded.</td>
<td>These are one-off costs.</td>
</tr>
</tbody>
</table>

115 [www.ukgttnhs.uk/gtn/Home](http://www.ukgttnhs.uk/gtn/Home)
612. The inclusion or exclusion of national screening programmes varies. Table 40 clarifies the treatment of each programme. Please note that any subsequent tests or investigations as a result of the screening process should not be excluded.

**Table 40: UK national screening committee programmes**

<table>
<thead>
<tr>
<th>Programme</th>
<th>Included or excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antenatal and newborn</strong></td>
<td></td>
</tr>
<tr>
<td>NHS Fetal Anomaly Screening Programme</td>
<td>Included in relevant maternity outpatient and admitted patient costs.</td>
</tr>
<tr>
<td>NHS Infectious Diseases in Pregnancy Screening Programme</td>
<td>Included in relevant maternity outpatient and admitted patient costs.</td>
</tr>
<tr>
<td>NHS Linked Antenatal and Newborn Sickle Cell and Thalassaemia Screening Programme</td>
<td>Included in relevant maternity outpatient and admitted patient costs. Exception is the small number of genetic tests, which are excluded and should be funded directly by CCGs.</td>
</tr>
<tr>
<td>NHS Newborn and Infant Physical Examination Screening Programme</td>
<td>Included in the cost of maternity delivery HRGs or postnatal visits.</td>
</tr>
<tr>
<td>NHS Newborn Blood Spot Screening Programme</td>
<td>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.</td>
</tr>
<tr>
<td>NHS Newborn Hearing Screening Programme</td>
<td>Included in audiology services neonatal screening (paragraph 507).</td>
</tr>
<tr>
<td><strong>Young person and adult</strong></td>
<td></td>
</tr>
<tr>
<td>NHS Abdominal Aortic Aneurysm Screening Programme</td>
<td>Excluded</td>
</tr>
<tr>
<td>National Screening Programme for Diabetic Retinopathy</td>
<td>Included in diabetic retinal screening, which should be reported as a directly accessed diagnostic service against HRG WH15Z.</td>
</tr>
<tr>
<td>NHS Breast Screening Programme</td>
<td>Excluded</td>
</tr>
<tr>
<td>Programme</td>
<td>Included or excluded</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>NHS Cervical Screening Programme</td>
<td>Excluded</td>
</tr>
<tr>
<td>NHS Bowel Cancer Screening Programme</td>
<td>Excluded</td>
</tr>
<tr>
<td><strong>Related programmes</strong></td>
<td></td>
</tr>
<tr>
<td>Health check (vascular risk)</td>
<td>Excluded</td>
</tr>
<tr>
<td>Chlamydia screening</td>
<td>Excluded</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>Excluded</td>
</tr>
</tbody>
</table>

613. Table 41 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 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 and PLICS.

**Table 41: PFI and LIFT expenditure**

<table>
<thead>
<tr>
<th>Heading</th>
<th>Comment</th>
<th>Treatment of costs in reference costs and PLICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of services</td>
<td>Include</td>
<td></td>
</tr>
<tr>
<td>Depreciation charges</td>
<td>Include</td>
<td></td>
</tr>
<tr>
<td>Dual running costs</td>
<td>For services transferring</td>
<td>Include. Double-running costs for all other service reconfigurations, etc are included.</td>
</tr>
<tr>
<td>Interest expense</td>
<td>Include</td>
<td>Include. This includes the indexed elements of PFI payments that do not relate to services.</td>
</tr>
<tr>
<td>Interim services (including pass-through costs)</td>
<td>Facilities management costs transferred early</td>
<td>Include</td>
</tr>
</tbody>
</table>

\[116\] Not approved by the UK national screening committee.
<table>
<thead>
<tr>
<th>Heading</th>
<th>Comment</th>
<th>Treatment of costs in reference costs and PLICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subleasing income</td>
<td></td>
<td>Include. Income generated from any subleased areas should be deducted from overall PFI costs.</td>
</tr>
<tr>
<td>Accelerated depreciation</td>
<td></td>
<td>Exclude.</td>
</tr>
<tr>
<td>Advisor fees</td>
<td>External advice provided to the provider</td>
<td>Exclude. Set-up costs (principally fees) incurred by the trust in developing a PFI scheme can be excluded.</td>
</tr>
<tr>
<td>Annual capital expenditure</td>
<td>Such as lifecycle costs</td>
<td>Exclude. The costs of capital items are picked up through depreciation in the same way as all other capital assets.</td>
</tr>
<tr>
<td>Demolition costs</td>
<td>These are works undertaken and paid for by the trust outside the PFI contract</td>
<td>Exclude. If the scheme were to be funded through public capital, this is likely to be capital expenditure.</td>
</tr>
<tr>
<td>Impairment charge</td>
<td></td>
<td>Exclude. This is consistent with the principle that reference costs reflect ordinary ongoing revenue costs and exclude extraordinary one-off costs unless otherwise stated.</td>
</tr>
<tr>
<td>Project team</td>
<td>Provider project team</td>
<td>Exclude. Set-up costs (principally fees) incurred by the provider in developing 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.</td>
</tr>
<tr>
<td>Profit on sale of surplus land or buildings</td>
<td></td>
<td>Exclude</td>
</tr>
<tr>
<td>Repayment of finance lease</td>
<td></td>
<td>Exclude</td>
</tr>
<tr>
<td>Other costs</td>
<td>Other payments not made to PFI provider</td>
<td>Other costs incurred by the provider 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 provider costs as directed in this guidance.</td>
</tr>
</tbody>
</table>
20: Reconciliation

Introduction

614. This section describes the process required to reconcile cost and activity data submitted in both the reference costs workbook, and the PLICS data extracts to both the final audited accounts and national datasets, eg HES.

615. The following worksheets in the reference costs return will provide assurance that the correct quantum of both costs and activity, have been for reference costs and PLICS.

- **Cost reconciliation**: this reconciles each provider’s national cost quantum to the audited annual accounts.
- **Activity reconciliation**: this is new for 2018, and will reconcile the activity data submitted for both reference costs and PLICS to HES/Secondary Uses Service for acute providers.
- **Drugs and devices**: there will be a drugs and devices worksheet in the reconciliation section of the workbook. This will allow the detail of cystic fibrosis drugs and high cost devices that have been excluded.
- **Survey**: a mandatory survey to collect information on the trusts’ costing infrastructure and the progress on their CTP journey, including clinical engagement.

616. We recommend that all providers review the reconciliation statement at the start of the costing process. Identify and exclude services detailed in Section 19: Services excluded from the national cost collection within your general ledger or your costing system, and other costs (or income) relating to non-patient care activities. You will also need to obtain values from the final accounts: some of them require further breakdown in the national cost collection financial reconciliation. This will provide confidence that the correct cost quantum has been established before costing services.

617. All providers should review and complete the following process:

- ensure the financial accounts are closed and the final version of the general ledger is available
- obtain the final trial balance or the general ledger output, or both, and ensure they agree, at detailed account code level
• 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

• check that the figures obtained in the step above agree to the final audited accounts spreadsheets; it may be necessary to ask colleagues in financial accounts for this information

• complete the reconciliation worksheet to the total costs and ensure this agrees to the trial balance/download

• check the data against last year’s to identify any material or unexpected variations, and investigate if needed

• import this quantum into the costing system

• 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

• ensure the total cost quantum in the completed reference costs workbook agrees to the total cost submission quantum on the reconciliation worksheet

• complete the drugs and devices worksheet if required

• do a final check of the reconciliation statement against last year’s to identify any material or unexpected variations, and investigate if needed.

Non-patient care activities

618. The national cost collection is mainly concerned with the collection of the cost of NHS patients who are funded by NHS commissioners in England.

619. Education and training, research and development, and commercial or other activities not primarily related to providing care to NHS patients or funded from sources other than contracts with NHS commissioners, are not reimbursed through national prices.

620. To date, our approach has been to require providers 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 reduces reference costs below the real cost of providing patient care. Similarly, if income is less than costs, this increases reference costs above the real cost of providing patient care.

621. Although we are pausing the collection of education and training (E&T) costs this year, we want to retain and build on your understanding of the E&T service. The E&T
technical working group will produce a transitional methodology for netting off E&T income to ensure everyone is following the same methodology in their costing processes. This will be released with this guidance as part of the Approved Costing Guidance.

622. Allowable income should be matched to the service where the income was generated, offsetting the cost of providing the service.

623. The treatment of other operating income from non-patient activities will remain the same for reference costs in 2018.

624. We will, however, ask you to identify the cost of these non-patient activities and submit them as a memorandum item, to enable NHS Improvement to carry out an impact assessment that will inform future decisions.

Reconciliation worksheet

625. The reconciliation section of the submission workbook will service both the reference costs and the PLICS submission. The layout of the reconciliation statement has been redesigned, which will make the process clearer for validation and assurance, as well as minimise the burden on trusts.

626. There is a single reconciliation worksheet for both NHS trusts and NHS foundation trusts, to be completed in £ not in £ thousands.

627. The worksheet will reconcile to data recorded in the audited financial statements to the total cost quantum. We have reordered the reconciliation statement to be more in line with the financial statements. Line references are included where applicable.

628. Providers obtaining foundation trust status part-way through a financial year must include the total of their provider finance monitoring returns to balance back to their total reference cost quantum. **Line 6: Other gains and losses** is Line SCI0210 in TAC02. Where there are other presentational differences – eg finance costs unwinding of discount – these are dealt with in Line 20. However, all costs must be included.

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

630. Net gain or loss on transfer by absorption is not included when calculating reference costs, and therefore there is no line on the worksheet.

631. We provide below a brief description of each of the lines included in the worksheet.

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

633. Where a provider produces a consolidated set of accounts, the expense figure shown in Line 1 should be the total operating expenses of the consolidation.

634. **Line 2: 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 TAC02 SoCI subcode SCI011A:

- **Line 2a: Non-salaried education and training income**
- **Line 2b: Salaried education and training income** – only income that should be reported under lines 13a and 13b of the reconciliation statement is income that relates to training programmes included in the E&T cost collection. All other training income (eg NVQs/apprenticeships) should be included in Line 2e.
- **Line 2c: Research and development centrally funded** – comprises several funding streams. Only R&D income from the government, relating to costs that end when the research ends, should be deducted here.
- **Line 2d: Research and development privately funded** – comprises several funding streams. For reference costs, only R&D income from the private organisations relating to costs that end when the research ends should be deducted here.\(^{117}\)
- The following funding streams are allowable income and should be spilt into either centrally funded or privately funded:
  - Research: research grant funding, to pay for the costs of the R&D itself (eg writing the research paper), received from the Department of Health and Social Care (including the National Institute for Health Research – NIHR), other government departments, charities, and the Medical Research Council (MRC),

\(^{117}\) Providers whose ledger is not set up at this level of detail should submit all R&D income against Line 3c. Please establish your ledger so that R&D can be separately identified in future.
which includes funding for biomedical research centres, biomedical research units and collaborations for leadership in applied health research and care (CLARHC).

- NHS support: funding from the Department of Health and Social Care (NIHR) to cover extra patient care costs associated with the research (eg extra blood tests, extra nursing time) that end when the research ends.
- Flexibility and sustainability funding: funding from the Department of Health and Social Care 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:
  - 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.
  - Subventions: exceptional funding from the Department of Health and Social Care to contribute to the cost of very expensive excess treatment costs.

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

- **Line 2e:** All other operating income not detailed above – the total of lines 2a, b, c, d and e should reconcile to the ‘Other Operating Income’ on TAC02 SoCI110A.

635. **Line 3:** Less finance income (foundation trusts) or investment revenue (NHS trust) is interest received.

636. **Line 4:** Add finance expenses financial liabilities (foundation trusts) or finance costs (NHS trusts)

637. **Line 5:** Add PDC dividends payable is the public dividend charge payable figure from the statement of comprehensive income, not the cash flow figure.

638. **Line 6:** Other gains (less) and losses (add) including sale of assets – 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.

639. **NEW** Line 7: **Share of profit (less) or loss (add) of associates/joint ventures** should be adjusted for here, as it is not allowable.

640. **Line 8: Other gains (less) and losses (add) from transfers by absorption** – 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.

641. **NEW** **Line 9: Corporation tax (if applicable)** – corporation tax relating to subsidiaries should be added back here.

642. **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:

- **Line 10a: New build**
- **Line 10b: Other.**

643. **Line 11: Add reversal of impairments** – conversely, the reversal of an impairment must be added back. These should be split between:

- **Line 11a New build**
- **Line 11b Other.**

644. **Line 12: Less PFI, LIFT, exclusions** – the set-up costs of PFI or LIFT schemes should be recorded on Line 29a. 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.

645. **Line 13: Less depreciation related to donated/government granted non-current assets** and **Line 14: 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 3), 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.

646. 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. The process in 2018 is the same as in 2017.

647. In the year when the asset is received, the provider 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 (ie the depreciation charge, etc), all income and expenditure relating to donated assets must be excluded from reference costs.

648. 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.

649. **Line 14**: Add donations/government grants received to fund non-current assets – please see line 13 above.

650. **NEW** **Line 15**: Add back STF income – this income is non-allowable and must be added back to the cost quantum in this line.

651. **Line 16**: Add other not allowable income – add back income included in Line 2e that cannot be netted off or is reported elsewhere. Income included in Line 2e that cannot be netted off when calculating reference costs (because it relates to patient care activities), must be added back on this line. (Examples include winter pressure monies, CQUIN, transitional relief and targeted patient care or injury cost schemes, but only where these costs have been included in Line 3 above)

652. Income included in **Line 2** above that is reported separately on other lines of the reconciliation statement (eg funds received for foundation trust application, centrally

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funded clinical excellence awards) should be added back here and reported separately on the appropriate lines of the statement to avoid double counting).

653. Please see Table 42 and Table 43 for details of what operating income is allowable and not allowable.

**Table 42: Not allowable non-contractual income**

<table>
<thead>
<tr>
<th>Item</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E patient experience fund</td>
<td></td>
</tr>
<tr>
<td>Access, booking and choice funding</td>
<td></td>
</tr>
<tr>
<td>Cancer service collaborative</td>
<td></td>
</tr>
<tr>
<td>Capital to revenue transfers</td>
<td></td>
</tr>
<tr>
<td>Coronary heart disease (CHD) collaborative</td>
<td></td>
</tr>
<tr>
<td>Clinical audit funding</td>
<td></td>
</tr>
<tr>
<td>Department of Health and Social Care funding for specific projects, eg disability equipment assessment</td>
<td>Not allowable unless targeted income specified in the allowable list above.</td>
</tr>
<tr>
<td>Emergency services collaborative</td>
<td></td>
</tr>
<tr>
<td>Income and expenditure surplus from a previous year</td>
<td></td>
</tr>
<tr>
<td>Improvement partnership for hospitals</td>
<td></td>
</tr>
<tr>
<td>Information for health</td>
<td></td>
</tr>
<tr>
<td>Information for health modernisation fund</td>
<td></td>
</tr>
<tr>
<td>Injury cost recovery (ICR) scheme</td>
<td>This is a reimbursement via a central government agency and should not be treated any differently to contractual income from PCTs: ie it is included in reference costs.</td>
</tr>
<tr>
<td>Item</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Maternity liaison committee</td>
<td></td>
</tr>
<tr>
<td>Reimbursements from manufacturers for device recalls</td>
<td>This only applies where the income is treated as non-NHS income. If it is treated as NHS income, no adjustment is required.</td>
</tr>
<tr>
<td>Social service income staff</td>
<td>If pooled budget arrangement, services should be excluded.</td>
</tr>
<tr>
<td>Transitional relief</td>
<td>Transitional relief is sometimes provided to offset exceptional costs, eg PFI schemes.</td>
</tr>
</tbody>
</table>

**Table 43: Other allowable non-contractual income**

<table>
<thead>
<tr>
<th>Item</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption medical fees</td>
<td></td>
</tr>
<tr>
<td>Administration charges</td>
<td></td>
</tr>
<tr>
<td>Advertising</td>
<td></td>
</tr>
<tr>
<td>Beverages and meals</td>
<td></td>
</tr>
<tr>
<td>Cancer network</td>
<td></td>
</tr>
<tr>
<td>Car parking</td>
<td></td>
</tr>
<tr>
<td>Catering</td>
<td></td>
</tr>
<tr>
<td>Charitable contributions to non-pay expenditure</td>
<td></td>
</tr>
<tr>
<td>Charitable income</td>
<td></td>
</tr>
<tr>
<td>Clinical excellence awards</td>
<td></td>
</tr>
<tr>
<td>Clinical trials</td>
<td>But see exclusions list. Associated activity must be excluded from reference costs, similar to private patients.</td>
</tr>
<tr>
<td>Conferences</td>
<td></td>
</tr>
<tr>
<td>Copy X-ray income for legal cases</td>
<td></td>
</tr>
<tr>
<td>Continuing professional development (CPD)</td>
<td></td>
</tr>
<tr>
<td>Copying</td>
<td></td>
</tr>
<tr>
<td>Court order administration fees</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Notes</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Court work</td>
<td>If this work is undertaken during NHS time, the employer is entitled to retain the fee, unless the disruption to the NHS is minimal and the employer agrees otherwise. In these circumstances, include costs, net of income and exclude activity. If the work is undertaken in the consultant’s own time, including during annual or unpaid leave, there is no cost to the NHS provider.</td>
</tr>
<tr>
<td>Drugs income for drugs supplied to other NHS trusts and pharmacists</td>
<td></td>
</tr>
<tr>
<td>Educational courses</td>
<td></td>
</tr>
<tr>
<td>External research income</td>
<td></td>
</tr>
<tr>
<td>GP co-operatives</td>
<td></td>
</tr>
<tr>
<td>Hospital shop leases</td>
<td></td>
</tr>
<tr>
<td>Hospitality</td>
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<td>Income generation schemes</td>
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<td>Interest received on cash deposits</td>
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<td>Investments</td>
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<td>Lease cars</td>
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<td>Lecture fees</td>
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<td>Lifting</td>
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<td>Lodging charges</td>
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<td>Miscellaneous income</td>
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<td>Mortuary fees</td>
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<td>Moving and handling</td>
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<td>NHS learning accounts</td>
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<td>National vocational qualifications (NVQs)</td>
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<td>Occupational therapy sales</td>
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<td>Operating theatre and preoperative assessment programme</td>
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<td>Paycare Commission</td>
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<td>Photography</td>
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<td>Item</td>
<td>Notes</td>
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<tr>
<td>Provider-to-provider (PTP) handling charges</td>
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<td>Prescription income</td>
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<td>PTP income</td>
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<td>PTP VAT to pay</td>
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<td>Receipts in advance</td>
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<td>Reclaims and rebates</td>
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<td>Rent and rate deductions</td>
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<td>Rent of land and premises</td>
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<td>Research and development</td>
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<td>Restroom hospitality and takings</td>
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<td>Safer cities</td>
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<tr>
<td>Salary recharges</td>
<td>To charities, universities (eg for staffing university sessions on an MRI scanner) and other non-NHS bodies (eg clinical pathology accreditation).</td>
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<tr>
<td>Sale of baby scan photos</td>
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<td>Sale of inventory items</td>
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<td>Sale of scrap</td>
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<td>Silver recovery</td>
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<td>Staff meal deductions</td>
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<td>Telephones</td>
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<td>Training income</td>
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<td>Unclaimed patients property</td>
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<td>Vending machines sales</td>
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<td>World Health Organisation (WHO) income</td>
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</table>

654. **Line 17: 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 3e: Other operating**
income, the amount must be added back in Line 16 to be deducted here, to avoid double netting off.

655. **Line 18: Less funds received for foundation trust application** – where these are included in **Line 2e: Other operating income**, the amount must be added back in here.

656. **Line 19: Less set-up costs for vanguard sites.**

657. **Line 20: 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 8.**

658. **Line 21: Less adjustment for provider-to-provider agreements.** Where there are provider-to-provider agreements for support services (eg an administration service, or a service where a provider pays for expenditure on behalf of another provider and is then reimbursed) or treatment services, the costs and associated income should be treated as in Figure 9.

**Figure 9: Provider-to-provider agreements**

659. The providing provider (A) 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 2.**
- (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 be deducted further on in the reconciliation. Where the treatment is provided to an NHS patient in another NHS provider, the costs will need to be deducted in **Line 21.** Any activity should be excluded from the reference costs workbook.
660. The receiving provider (B) should:

- (for support services) include the cost paid to the providing provider in its own reference costs, allocated and apportioned on a consistent basis, as if it had provided the service itself; there should be no need for an adjustment in **Line 21**
- (for treatment services) follow the same approach as for support services, recording both the costs and activity in its reference costs return.

661. **Line 22:** Add income received from other providers for maternity pathways.

662. **Line 23:** Less payments made to other providers for maternity pathways.

663. **Lines 24 to 27** are user-defined rows that have been left for providers to add adjustments that have not been included in the reconciliation. **Full details of the adjustment must be provided and must have been agreed with NHS Improvement via email** (costing@improvement.nhs.uk) **in advance of the submission.**

664. The entries on these lines will be monitored throughout the collection window; if NHS Improvement finds entries with no prior agreement or no suitable explanation it may contact the provider in question.

665. **Line 28:** **Services excluded from reference costs collection** as listed in Section 19: Services excluded from the national cost collection.

666. **Line 29aa:** **Cost of non-NHS private patients** – deduct the costs of providing care to private patients who are funded by private medical insurers or pay for treatment themselves. Patients who are managed by a third party organisation, but on behalf of an NHS commissioning body, should **not be** excluded from cost information submitted. If in doubt, please contact us at costing@improvement.nhs.uk.

667. **Line 29ab:** **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 living overseas. Do not deduct the costs of overseas patients (reciprocal).\(^{119}\) Their care is commissioned via the CCG and should be included in reference costs as though they were registered or resident in England.

\(^{119}\) Including patients from the Isle of Man and Jersey (but not other Channel Islands), with whom the UK government has reciprocal healthcare agreements.
668. **Line 29ac: Less cost of other non-NHS patients** – deduct the costs of providing care to the following non-NHS patients:

- 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 (eg 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.\(^{120}\)

- Patients from the devolved administrations (Scotland, Wales and Northern Ireland) – Parliament sets the NHS budget based on the requirements of NHS patients in England: ie those resident in England and legally entitled to NHS care.

669. **Line 29ad: Less cost of outsourced activity** – deduct the costs of outsourced activity on this line depending on the outcome of the consultation. This refers to patient activity rather than outsourcing of functions: eg payroll.

670. **Line 30: Total reference cost submission quantum** is the sum of lines 1 to 29 and must agree to within +/- 1% of the main reference cost submission.

**Drugs and devices**

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

672. To inform price setting, as well as 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. 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.

\(^{120}\) [www.gov.uk/government/publications/health-services-for-the-armed-forces-and-veterans](www.gov.uk/government/publications/health-services-for-the-armed-forces-and-veterans)