Reference Costs 2006
Collection – Guidance

Reference Costs 2006 Collection

Costing & Activity Guidance and Requirements

Contents

This document acknowledges the vital contribution made by all members of the NHS 2006 Guidance Working Group, and thanks them for their participation, stamina, & unswerving attention to detail

Reference Costs 2006 Collection

Costing & Activity Guidance and Requirements

Overview

This document outlines the mandatory requirements for the 2006 reference costs collection. It supercedes costing guidance issued in previous years. It should be read in conjunction with the latest version of the NHS Costing Manual (1). It is the Department's intention to regularly update the NHS Costing Manual, to ensure that current best practice is implemented throughout the NHS. Staff with an interest in costing are strongly advised to check the costing website (1) regularly.

The guidance makes minimal changes to the 2005 collection. The focus for 2006 remains one of refinement and increased consistency rather than of extension of scope. This is a conscious decision to enable costing teams to focus on improved quality. There are a few changes, made necessary by:

- Refinements and requirements needed to support the new national tariff system (Payment by Results);
- Data required to monitor implementation of National Service Frameworks;
- The development of a national system of programme budgets; and
- Withdrawal of the TFR2.

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

An electronic version of this guidance will be made available on the DH website (1) (2).

Payment by Results (*PbR*)

Reference costs data is used to inform the national tariff under Payment by Results. It is therefore essential that the Reference Cost collection is of the highest quality and accuracy. It is also vital that deadlines are met in order to issue the national tariff for 2007/08 on a timely basis.

Significant interest in the quality and accuracy of the return by External Auditors and the Audit Commission is expected to continue.

Action

Reference Cost returns (data files and relevant statements) are required to be returned to DH by **Friday 30th June 2006**.

References

(1) http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSCostingManual/fs/en
(2) http://194.200.241.107/fd/refcostsdisc.nsf/main?readform.

Section 1 - Introduction

1 This guidance sets out the mandatory requirements for the reference cost collection which is an activity and cost return for NHS patients. This return has been approved by the Review of Central Returns Committee which mandates its collection across the NHS. Reference costs are part of the financial regime for NHS Trusts, NHS Foundation Trusts, Primary Care Trusts and Care Trusts as designated in relevant NHS legislation and guidance. In addition, PCTs are required to submit a return for each of their respective Personal Medical Services plus Pilots (PMS+), for the plus element of their agreements. It is the responsibility of PCTs to ensure that appropriate PMS+ data is identified and submitted for each PMS+ organisation, irrespective of whether the PMS+ services have been incorporated into PCT responsibilities or not.

2 **This guidance applies to all NHS organisations in existence from 1st April 2005 to 31st March 2006. Where these organisations have ceased to exist in March 2006, it is the responsibility of successor organisations to ensure reference cost returns are submitted by the mandatory deadline.** This follows the same principle as final accounts returns.

3 The service coverage has not been expanded for the 2006 collection. However, a number of refinements have been introduced in order to provide further clarity to the guidance, ensure greater comparability, and produce greater robustness in activity and cost data.

4 All NHS organisations (providers, commissioners, and regulators) are expected to comply fully with this guidance, and its timescales. Each organisation must ensure that it has the necessary resources and systems to meet full compliance. The deadline for the submission of completed returns to the Department of Health is no later than **30th June 2006**.

Data Quality

5 There continues to be improvements in the quality of data. However, there are still a number of organisations where data quality issues are unresolved e.g. levels of unclassified data, erroneous clinical coding, etc. The onus on the production of sound, accurate and timely data rests with each NHS organisation. This is reinforced in the organisational reports on the reference costs collection, which state explicitly that;

"…*(T)he data used in the attached analysis was supplied by your own (NHS) Trust and that data accuracy is the responsibility of your own Board".*

6 The implications of poor quality activity and cost data are now far-reaching and will impact on the financial position of each NHS organisation under the PbR program. **The need for high quality data cannot be underestimated.**

7 Work has been ongoing on data quality and data accreditation programmes. This continues to be supplemented by additional central data quality checks, and by the inclusion of reference costs in the Audit Commission's audit programme. The findings of this audit will be fed back directly to the NHS.

Key Principles

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

- Reference costs are retrospective, and the quantum of costs used in their production should be reconciled to the 2005 / 06 final accounts. The reconciliation statements that form part of the return are an integral element of the audit trail for this reconciliation.

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

- Reference costs are based on full absorption costing.

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

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

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

A detailed reconciliation to the final accounts figures using TAC / ASF figures is provided in Appendices 2 and 3 of this document.

10 It is also expected that an annual review of overhead apportionments is undertaken. It is important to review apportionments across the individual points of delivery within a service / specialty, and not just the apportionments to individual services / specialties. This is an area where auditors have been requested to undertake specific checks.

11 All NHS organisations, that provide any of the services listed in the subsequent sections, are required to make a submission of all relevant information to the Department of Health by **30th June 2006.**
In addition, PCTs and NHS Trusts who directly commission or sub-contract services from non-NHS health care providers, including Independent Sector Treatment Centres, are required to make a separate composite return. As in 2005, NHS organisations are required to make a single set of composite returns for any and all services that are sub-contracted (in the case of Trusts and PCTs acting in their provider capacity) or commissioned (for PCTs acting in their commissioning role) from non-NHS providers. This will ensure that the total cost of treating NHS patients is identified whether the provision is made by NHS or non NHS providers.

12 Details of the 2006 collection process will be published on the reference cost website in spring 2006. It is anticipated that the format used in 2005 will be retained.

13 Strategic Health Authorities have a key role in performance managing the process, and in supporting NHS organisations in complying with current guidance and requirements. A lead member of staff is identified for each Strategic Health Authority and contact details can be found in Annex 1 at the end of this document.

Trimpoints

14 Inpatient and day case services primarily use Healthcare Resource Groups (HRGs) as their casemix measure. As in 2005, Version 3.5 HRGs should be used for reporting this type of data. In calculating the HRG length of stay and associated excess bed days, the revised Finished Consultant Episode (FCE)

national trimpoints should be used. These can be accessed in .csv format on disk from the NHS Information Centre* website (www.icservices.nhs.uk/casemix). These trimpoints are calculated using historic data and ensure that the prudence concept for accounting purposes is maintained.

15 FCE excess bed days are those bed days that fall beyond the upper trimpoint for an HRG after truncation. Costs and activity should be reported separately within reference costs. It is expected that the care of patients is less intensive/dependant than at the beginning of the FCE and thus costs will be less per day than for the truncated HRG.
Excess bed days should include appropriate costs for the level of care provided and as a minimum should include the following cost pools:

- Hotel services
- Nursing
- Therapy services
- Ward consumables
- Drugs
- Diagnostics, medical staffing and other cost pools should be included only where appropriate and where their inclusion can be justified to Audit, if required.

16 **All unclassified data (U code HRGs)** has a trim point of zero. All bed days relating to unclassified data for inpatient activity should therefore **be reported as excess bed days** and costed accordingly in line with guidance in paragraph 15. Thus, U code costs may include elements of costs for theatres, pathology and radiology services, etc. It should be noted that, as in 2005, the costs and activity relating to U codes are **NOT included in Index calculations**.
As in 2005, FCE activity for U code data continues to be required as a memorandum item for elective and non-elective inpatient data to complete the collection files. No cost per FCE should be reported for inpatient unclassified HRGs.
U code data reported at day case level should continue to be reported on an FCE and unit cost per FCE basis, given that, by its very nature, there are no bed days associated with day case activity.

17 For services reported using bed days rather than inpatient FCEs, e.g. critical care services, the relevant bed days should be **excluded** prior to the application of the version 3.5 national trimpoints.

18 Full details on the truncation of inpatient episodes and the treatment of excess bed days can be found in the NHS Costing Manual.

19 This guidance applies to the provision of health services to NHS patients from NHS resources. In previous years the Department of Health has set a minimum level of expenditure that must be incurred for costs and activity to be included in the collection exercise. In 2006 this de minimis level remains at 2%, i.e. where the quantum of costs for reference cost purposes is 2% or less of the total level of expenditure on all NHS services, NHS providers are exempt. However, it is expected that the exemption will apply to NHS Learning Disability service providers only.

Costing of Reference Costs

20 The principles and mandatory framework set out in the NHS Costing Manual should form the basis of costing for the production of Reference Costs. As part of the Controls Assurance Framework to achieve costing and cost information on a consistent basis, the Accountable Officer will continue to be required to sign the Internal Control Statement. Costing information is subject to audit. In addition, Directors of Finance are required to sign a Statement of Compliance, acknowledging that the information provided is a true and fair view of the services provided, in cost and activity terms.

21 To ensure that all NHS providers are compared on a consistent basis, details of the definitions to be used and refinements to the standard costing approach that must be adopted are detailed below. Comprehensive information on the overall concepts and approach to costing NHS Services can be found in the NHS Costing Manual, available on the internet at http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSCostingManual/fs/en.

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

Section 2 – Elective Inpatients, Non-Elective Inpatients, Day Cases, Ward Attenders and Attenders at Day Care Facilities

23 Inpatient and day case services should be reported using Version 3.5 HRGs (not version 3.1 HRGs). These groupings have been approved for use by the Information Standards Board and the Review of Central Returns Committee. A Data Set Change Notice was issued in October 2003 to this effect.

24 The unit cost and activity in these categories should be reported at Healthcare Resource Group (HRG) level unless otherwise specified. In addition, information on the number and unit cost of excess bed days for inpatient stays should be reported. Where a clinician or nurse undertakes inpatient or day case activity whilst acting in a private capacity, these are not recorded against the NHS organisations activity and cost base and therefore are excluded from the exercise from a provider perspective.

25 An updated national specialty list was issued in DSCN 34/2003, in July 2003, effective from 1st April 2004. Details of the revised specialties can be found on the NHS Information Centre* website.

26 For the 2006 collection, therefore, NHS organisations should report data for the following: -

Code	Treatment Function Title / Other	Comment
100	General Surgery	
101	Urology	
102	Transplantation Surgery	
103	Breast Surgery	
104	Colorectal Surgery	
105	Hepatobiliary & Pancreatic Surgery	
106	Upper Gastrointestinal Surgery	
107	Vascular Surgery	
110	Trauma & Orthopaedics	
120	ENT	
130	Ophthalmology	
140	Oral Surgery	
141	Restorative Dentistry	
142	Paediatric Dentistry	
143	Orthodontics	
144	Maxillo-Facial Surgery	
150	Neurosurgery	
160	Plastic Surgery	
161	Burns Care	To be used by recognised specialist services only
170	Cardiothoracic Surgery	
171	Paediatric Surgery	
172	Cardiac Surgery	
173	Thoracic Surgery	
174	Cardiothoracic Transplantation	To be used by recognised specialist services only
180	Accident & Emergency	
190	Anaesthetics	Not a Treatment Function – retained only for completeness
191	Pain Management	
192	Critical Care Medicine	Not reported using HRGs – see Section 3
300	General Medicine	
301	Gastroenterology	
302	Endocrinology	
303	Clinical Haematology	
304	Clinical Physiology	Not a Treatment Function – retained only for completeness
305	Clinical Pharmacology	

Code	Treatment Function Title / Other	Comment
306	Hepatology	
307	Diabetic Medicine	
308	Bone & Marrow Transplantation	Recipient activity and costs not reported using HRGs – see Section 12
309	Haemophilia	
310	Audiological Medicine	
311	Clinical Genetics	
312	Clinical Cytogenetics and Molecular Genetics	Not a Treatment Function – retained only for completeness
313	Clinical Immunology & Allergy	
314	Rehabilitation	Not reported using HRGs – see Section 12
315	Palliative Medicine	
316	Clinical Immunology	
317	Allergy	
318	Intermediate Care	Excluded from RC – reported on Statement PSSC
319	Respite Care	
320	Cardiology	
321	Paediatric Cardiology	
322	Clinical Microbiology	
330	Dermatology	
340	Thoracic Medicine	
341	Sleep Studies	
350	Infectious Diseases	
352	Tropical Medicine	
360	Genito-Urinary Medicine	
361	Nephrology	
370	Medical Oncology	
371	Nuclear Medicine	Not a Treatment Function – retained only for completeness
400	Neurology	
401	Clinical Neuro-Physiology	
410	Rheumatology	
420	Paediatrics	
421	Paediatric Neurology	
422	Neonatology	
430	Geriatric Medicine	
450	Dental Medicine Specialties	
460	Medical Ophthalmology	
501	Obstetrics	
502	Gynaecology	
503	Gynaecological Oncology	
560	Midwife Episode	
800	Clinical Oncology	
810	Radiology	Support Service. Reported as part of composite HRG, outpatients, or services accessed directly (see Section 13
811	Interventional Radiology	Can also be a support service. Reported as part of composite HRG, outpatients, or services accessed directly (see Section 13
822	Chemical Pathology	Can also be a support service. Reported as part of composite HRG, outpatients, or services accessed directly (see Section 13
997	Podiatry	Acknowledged in Reference Costs only. To include Podiatric Surgery where necessary.
999	Global Trust Costs	Not a Treatment Function; applicable to Reference Costs only

27 Some NHS organisations have opted to report procedure and treatments on an organisational wide, rather than specialty specific, basis. In this situation, costs and activity should be reported using Specialty code 999, which has been retained for 2006. The use of 999 should be kept to a minimum in 2006. It is anticipated that it will be withdrawn from future collections.

28 Although most inpatient services have been included in reference costs since their inception, some areas require refinement to ensure greater consistency, both in costing and activity.

29 The split between elective and non-elective inpatients is maintained. NHS providers are expected to continue to separate and return unit cost and activity data for both types of care where both are provided. Day case activity will continue to be separately reported as for previous collections.

30 Confusion has occurred previously where a patient has a planned or expected admission as an inpatient, but is allowed home on the same day. Within a number of patient administration systems, this will be recorded as an inpatient, with a length of stay of less than one day. To achieve consistency, the following **standard definition of length of stay should be used for inpatient episodes with a nil length of stay; date of discharge less date of admission plus one.** This definition is consistent with the recording of this data within other financial returns e.g. Trust Financial Returns, and with reference costs in previous years. Note that this adjustment should be made after filtering out the non-FCE activity, e.g. critical care, and after grouping the data, but before trimming.

31 Inpatient and day case activity is now included for all but a few NHS services. As a general rule, unless services are specifically listed as being excluded (see Section 17), they should form part of the reference costs collection.

32 As in 2005, the number and cost of excess bed days will be reported separately for elective and non-elective bed days. The report generator software, issued by the NHS Information Centre*, splits these excess bed days between elective and non-elective categories as a matter of course.

33 Inpatient submissions continue to include unit cost and Finished Consultant Episode (FCE) data. The 2006 collection still requires NHS providers to identify separate hospital spell information for inpatient episodes. To assist NHS providers in doing this software has been provided at no cost by the NHS Information Centre*. Details can be found on the NHS Information Centre* website at www.icservices.nhs.uk. Queries on this software should be addressed to their helpline on 01962 844588. As the national tariff is spell based, it is **vital** that the recording of spell data in the reference cost return is accurate. Organisations that do not submit spell data will be deemed to have submitted an incomplete return.

Inpatient / Day Case HRG Refinements

34 Over the last three years, a number of refinements have been included for inpatient and day case activity. The majority of these have related to the development of definitions for Specialist Commissioning. In some cases, this has led to the suspension of some existing HRGs, to reflect greater detail, to support greater consistency in costs, and to support commissioning developments e.g. the HRG code S09 for Bone Marrow Transplantation.

35 The 2006 collection retains all sub-HRG categories included in the 2005 collection. These were introduced for specific services or programmes of work that are not captured effectively by Version 3.5 HRGs. The use of these categories is viewed as an interim measure until the Version 4 HRGs are developed. It is hoped that Version 4 HRGs will fully reflect the complexity of those treatments and procedures / services that have entered mainstream clinical practice since the coding structure was developed in the early 1990s.

36 As in 2005, Defibrillator Implant & Explant costs and activity are separately identified. The full range of HRGs to capture this type of cost and activity data remains:-

- E08 Pacemaker Implant except for AMI, Heart Failure or Shock
- E08DF Pacemaker Implant except for AMI, Heart Failure or Shock – Defibrillator Implant & Explant only
- E09 Cardiac Pacemaker Replacement/Revision
- E09DF Cardiac Pacemaker Replacement/Revision - Defibrillator Implant & Explant only
- E15 Percutaneous Coronary Intervention
- E15DF Percutaneous Coronary Intervention - Defibrillator Implant & Explant only
- E0xDF Other - Defibrillator Implant & Explant only

37 Note that where defibrillator activity occurs in an HRG other than E08, E09 or E15, the E0xDF HRG identified above should be used. Organisations should use the same trimpoint for each defibrillator-specific HRG as for the non-defibrillator HRG, e.g. E08 and E08DF, E09 and E09DF, etc. For HRG E0xDF, the trimpoint for HRG E08 should be used.

38 The revised split for Kidney transplants introduced in 2005 will be maintained in 2006. Further details of this change can be found in the Specialist Services section (12) of this guidance.

Costing of Admission / Pre-Admission Wards, Assessment Units, Observation Wards

39 The approach that was adopted in 2003 for the costing of these types of ward and units has not changed. **Irrespective of whether these wards form part of the Accident and Emergency Department, they must be reported as detailed in paragraph 40**.

40 Costs associated with these beds / wards need to be separately identified for internal management purposes, and should continue to be **included as an overhead on the services / specialties that use the facility**, unless the patient activity starts and ends solely within this type of unit.
Thus the reporting requirement is as follows:-

- If the patient is later admitted to the provider, the costs of a stay in these beds will become an overhead on the admitting specialty.

- If activity starts and ends solely in one of these beds, it should be counted as a Finished Consultant Episode (FCE), allocated to an appropriate (V-prefix) version 3.5 HRG and costed accordingly. A separate sheet on the Accident and Emergency collection file enables this activity to be clearly identified and reported.

41 V-prefix HRG based costs and activity for these beds **will not** be aggregated into overall HRGs within the National Schedule of Reference Costs, but will be calculated and published separately. Costs and activity for these services will form part of the Reference Costs Index calculation.

Ward Attenders

42 *Ward Attendances*

"An attendance at a WARD by a patient for nursing care, where the patient is not currently admitted to that HEALTH CARE PROVIDER.
If the attendance is primarily for the purpose of examination or treatment by a Doctor, it is an OUTPATIENT ATTENDANCE (CONSULTANT) and not a WARD ATTENDANCE".
Activity and cost data relating to those patients attending for examination or treatment by a Doctor should be reported as part of the composite outpatient return, at specialty level. Further details can be found in the Outpatients section of this guidance.

43 Attendances for specialist care such as Chemotherapy, Radiotherapy, and Renal Dialysis, etc. should also be reported in reference costs in the appropriate file. All costs for these services are reported

together, irrespective of setting. The activity and costs of such care should NOT be reclassified as outpatients.

44 As notified in the 2005 Guidance, ward attender costs and activity are no longer required to be separately identified. Rather, they must be reported as part of the composite activity and unit cost of the outpatient return.

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

"A patient admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled, and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions".

In activity terms, a series of regular admissions would not become a finished episode for HRG purposes until the series ends. From a costing perspective, this can consume a significant level of resources over an extended period.

There is a continued requirement to report and cost this activity separately in 2006. These patients are admitted (with an intention of same-day discharge). As the on-going regime can extend over several months, the costing of completed regimes is deemed inappropriate. The costing of these regular day admissions will therefore be based on the number of admissions each year, and a cost per admission. These admissions will be shown separately, but will need to be matched to the relevant (RD-prefix) version 3.5 HRG classification.

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

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

"A patient admitted electively for the night, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled, and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions".

For reference costs, in activity and cost terms, these should be treated in the same way as regular day admissions (paragraph 46). In reporting this data, this activity and unit cost information will not be shown separately from regular day admissions. The return will identify regular day / night admissions in total, as the timing of the regular admissions is not considered to have a significant impact on cost.

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

Regular Attendances at Day Care Facilities

47 A range of services are provided through NHS day care facilities. In costing these services, the following definition of day care facilities, taken from the NHS Data Dictionary, should be used:

"A DAY CARE FACILITY provided for the clinical treatment, assessment and maintenance of function of PATIENTS, in particular, though not exclusively, those who are elderly, mentally ill or have learning difficulties. They may be called Day Hospitals, Centres, Facilities or Units.

DAY CARE FACILITIES may be financed, planned and run solely by NHS organisations or solely by non-NHS organisations or jointly between NHS and non-NHS organisations. Jointly run facilities should still be managed by only one ORGANISATION.

The facilities specifically do not have hospital beds and function separately from any ward."

48 The number of attendances per patient will vary due to the different nature of the patient's condition. Generally the number of places each day is fixed e.g. 20 patients each day and over 5 days this gives 100 patient days.

49 As in 2005, the 2006 collection requires that the costs and activity for these day hospitals/centres/units forms part of the collection for elderly, stroke, and mental health services. Centres catering primarily for the long term physically disabled and learning disability patients continue to be excluded (as all other services for these patient categories are also excluded).

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

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

Alternative Service Delivery

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

Community Hospitals

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

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

55 Further details of how Community Hospitals should report Rehabilitation services can be found in Section 13 of this document.

Mental Health

56 More details on the costing of mental health services can be found in Section 8 of this guidance. Mental health services are not generally recorded using HRGs for reference costs purposes.

Section 3 – Critical Care Services

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

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

59 Discrepancies can arise when counting occupied bed days for all types of Critical Care Services Activity. For reference costs purposes, counting of critical care services occupied bed days should follow the NHS 'midnight count' protocol. This means that an occupied bed day is only counted as such where a patient is occupying the bed at midnight. For example, 4 patients spending 5 hours in a bed, the latter being over the midnight count period, would be counted as 1 occupied bed day for that bed for that day.
The reported cost per occupied bed day must fully reflect the costs incurred on average for an entire day, taking into account, where appropriate, the additional costs incurred where more than one patient occupies that bed during a single day, for example, additional laundry / linen costs, etc.

60 Critical Care costs should include all costs associated with this part of the FCE. Costs will include medical staff costs of the admitting specialty as well as the medical cover provided by Anaesthetists.
The following cost pools would be expected:

- Hotel services
- Nursing
- Therapy services
- Medical staff
- Ward consumables
- Blood and blood products
- Drugs
- Diagnostics e.g. Pathology and Radiology
- Medical and Surgical Equipment (includes specialist equipment, e.g. CPAP and NIPPY machines)
- No theatre costs should be included as part of the critical care episode [but see paragraph 61].

61 As a general principle, it would be expected that a patient's treatment function would change on admission to a critical care unit. Thus theatre costs would not form part of total expenditure for critical care services.
Where this is not the case, and the patient's treatment function specialty does not change on admission to a critical care unit, theatre costs should be included as on overhead on the critical care service, and any activity disregarded.

62 In addition to occupied bed days calculated using the midnight count protocol, the 2006 collection continues to require additional memorandum activity information for all critical care services, in the form of Augmented Care Period Bed / Cot Days (ACP Bed / Cot Days). An ACP bed day is counted using calendar days, and any part of a calendar bed day should be counted as one, i.e. **date of discharge less date of admission plus one.** Note that a unit cost per ACP bed day is not required in 2006.

63 To clarify, the counting convention for each of the activity requirements for critical care as described in paragraph 62 can be illustrated as follows:-

Bed Day Type	**Admission Date & Time**	**Discharge Date & Time**	**Count**
Occupied Bed Day using Midnight Count Protocol	5th November 2005 13:00	7th November 2005 10.30	**2 OBD** (Midnight of 5th; Midnight of 6th)
ACP Bed Day	5th November 20054 13:00	7th November 2005 10.30	**3 ACP days** (7-5)=2+1=3

64 Activity and cost information is therefore required on a cot/bed day basis for the following types of Critical Care Unit, where those **units are discrete**: -

- Intensive Therapy Units / Intensive Care Units
- Burns Intensive Care Units
- Neurosurgery Intensive Care Units
- Liver Intensive Care Units
- Spinal Injuries Intensive Care Units
- Renal Intensive Care Units
- Cardiac Intensive Care Units
- Coronary Care Units
- High Dependency Units [discrete adult only, or adult and child combined]
- Paediatric Intensive Care Units
- Paediatric High Dependency Units [discrete paediatric HDU only]
- Neonatal Intensive Care Units

65 Where a Critical Care unit comprises of more than one type of critical care, e.g. a combined CCU and HDU, every effort should be made to distinguish between the costs and activity for each individual type.
It is advised that in the absence of any other data, providers should use the pro rata number of beds within a combined critical care unit to report appropriate costs and both occupied and ACP bed days between different categories of critical care.
Where specialist critical care beds are maintained, e.g. burns, neurosurgery, these should be reported separately in line with the definitions for specialist services.
Where separate reporting is not possible or feasible, combined data should be submitted in the lower grade category (see hierarchical list in paragraph 64), so as not to over-inflate available capacity. Thus, where a combined CCU and HDU exist, and individual service data cannot be identified and reported separately, all data should be submitted as HDU.

66 Discrete Non Invasive Ventilation Units should be reported as part of HDU for 2006, given the similarity in treatment function.

Adult Critical Care

67 In future collections it is intended that Critical Care HRGs, based on number of organs supported, will supercede current collection activity requirements.
In 2006, in line with the ultimate aim of collecting cost and activity data for levels of care provided rather than by type of Critical Care unit, cost data on an occupied bed day basis, and activity data on an occupied and on an ACP bed day basis, for the following **Adult Critical Care** services:-

- Intensive Therapy Units / Intensive Care Units
- Burns Intensive Care Units
- Neurosurgery Intensive Care Units
- Liver Intensive Care Units
- Spinal Injuries Intensive Care Units
- Renal Intensive Care Units
- Cardiac Intensive Care Units
- Coronary Care Units
- High Dependency Units [adult only, or adult and child combined]

is required to be separately identified and reported across the following categories:

- Level 3 Critical Care
- Level 2 Critical Care
- Level 1 Critical Care

68 Details of the patient's level of care should be available locally. For information, the proposed Critical Care Minimum dataset (CCMDS) uses the following definitions to determine the level of care provided:

- Level 3 Critical Care - patients require advanced support e.g. advance respiratory support alone or basic respiratory support of at least two organ systems. This level includes patients requiring support for multi-organ failure.
- Level 2 Critical Care - patient requires more detailed observation or intervention - e.g. required support for a single failing organ system or required post operative care.
- Level 1 Critical Care - patient at risk of a deterioration but whose needs can be met on an acute ward with additional support or advice from the critical care team.

69 **As notified in 2005, the option to report data using the '*no detailed data* available' category has been withdrawn in 2006.**

70 The collection for adult intensive care units will therefore be as follows:-

Adult Intensive Care Unit	**Unit Cost / OBD £**	**Total No. of Occupied Bed Days** (calculated per paragraph 63 illustration)	**Total No. of ACP Bed Days** (calculated per paragraph 63 illustration)
ICU Level 3 Critical Care			
ICU Level 2 Critical Care			
ICU Level 1 Critical Care			

71 The level of detail illustrated in paragraph 70 will be required for all adult critical care units as identified in paragraph 67.

72 Where children (up to and including 16) are treated in adult critical care units, the cost and activity data should be reported as part of the adult critical care unit. It is not necessary for organisations to separately identify activity relating to children, but undertaken in an adult unit, in 2006.

73 Note that, in line with tariff requirements, cost and activity data for discrete Coronary Care units may form part of the admitted patient care HRG cost and activity in 2007, rather than being separately identified as part of critical care services. However, in 2006, separate reporting for Coronary Care units continues.

74 In a further notification of future requirements, when approved, the new CCMDS will collect a wider range of organ support information. It is intended that the Reference Costs collection in future years will employ these organ support categories in order to classify cost and activity data. In the interim, Statement Z will continue to require detailed analysis, by level of organ support, for Adult Critical Care.

Paediatric Critical Care Units [includes Intensive Care and discrete High Dependency Units]

75 Discrete paediatric critical care units are reported using a single classification, as in previous years. As in 2005, discrete paediatric high dependency units are separately identified. [Note that where an HDU is adult only, or adult and child combined, this should be reported in line with the requirements listed in paragraphs 67 – 74]. Cost data will be reported on an occupied bed day basis and activity data on an occupied and on an ACP bed day basis. There is no requirement to identify data by level of care for these units.

76 **The collection for paediatric intensive care and paediatric discrete high dependency units remains as follows:-**

Paediatric Critical Care Services	**Unit Cost / OBD £**	**Total No. of Occupied Bed Days** (calculated per paragraph 63 illustration)	**Total No. of ACP Bed Days** (calculated per paragraph 63 illustration)
Paediatric Intensive Care Unit			
Paediatric High Dependency Unit			

Neonatal Intensive Care Units

77 The cost per cot day for neonatal intensive care units should be subdivided across the following bands:

- *Level 1 Intensive Care* (Maximum Intensive Care) i.e. care given in an intensive care nursery which provides continuous skilled supervision by qualified and specially trained nursing and medical staff. Such care includes support of the infant's parent(s).

- *Level 2 Intensive Care* (High Dependency Intensive Care) i.e. care given in an intensive or special care nursery which provides continuous skilled supervision by qualified and specially trained nursing staff who may care for more babies than Level 1 intensive care. Medical supervision is not so immediate as in Level 1 intensive care. Care includes support of the infant's parent(s).

- *Special Care* i.e. care given in a special care nursery, transitional care ward or postnatal ward, which provides care and treatment exceeding normal routine care. Some aspects of special care can be undertaken by the mother, supervised by qualified nursing staff. Special nursing care includes support and education of the infant's parent(s).

These classifications are based on definitions from the NHS data dictionary which clarifies the levels of neonatal care.

78 The collection for neonatal intensive care remains as follows:-

Neonatal Intensive Care Unit	**Unit Cost / OCD £**	**Total No. of Occupied Cot Days** (calculated per paragraph 63 illustration)	**Total No. of ACP Cot Days** (calculated per paragraph 63 illustration)
Neonatal Intensive Care Level 1			
Neonatal Intensive Care Level 2			
Special Care Baby Unit			

79 Note that where ACP data is not collected for all neonates within these types of unit, (e.g. some organisations do not collect ACP data for neonates less than 28 days old), please do not report any ACP data on the collection files. It is not acceptable for the ACP data reported for NICU / SCBU to relate only to certain patients within these types of units.

Critical Care Outreach Services

80 Many organisations have critical care outreach teams that operate outside the parameters of the discrete critical care unit. The costs of such teams should be included as an on-cost on the appropriate critical care unit, and any activity relating to these teams should be excluded. It is anticipated that in future years, as activity data capture for these outreach teams improves, the reference costs collection will require this information to be reported separately in both cost and activity terms. Note that where organisations have a dedicated, discrete critical care outreach team, whose entire activity is undertaken in a ward setting, the costs and activity of this team must be reported as an on-cost to Critical Care Services, but details of the costs and activity for such teams will be required to be separately identified on Statement Z.

Retrieval Services

81 Some organisations provide Neonatal and Paediatric ICU retrieval services. A definition of retrieval is as follows:-

"Children with critical illness of level 2 or 3 should be transferred to a tertiary centre (Lead PICU, except where this may not be in the immediate interests of the child. Transfers, therefore, should occur as a result of consultant to consultant referral. In the majority of cases, a Retrieval Team from the Lead PICU should effect the transfer. A small number of emergencies such as neurosurgical, burns, and some intra-abdominal conditions, in view of the grave urgency, will still need to be transferred by staff from the referring hospital."

"The Retrieval Team will compose of specifically trained medical staff and nursing or technical personnel using purpose-built equipment; ventilators, monitors, infusion devices, oxygen and air cylinders, and a range of instruments and disposables suitable for the wide age range involved'.

In order to ensure consistency across all NHS providers for the treatment and subsequent reporting of these costs, three new categories were introduced in 2004, which have been retained in 2006.

Only those organisations that provide such services, i.e. have a separately identifiable Adult (for completeness), Neonatal or Paediatric ICU Retrieval Service should report appropriate unit cost and activity data, e.g. unit cost per retrieval and total number of retrievals. In accordance with NHS costing principles, the reported cost per retrieval must fully reflect the costs incurred on average for each retrieval, and be calculated using full absorption costing methodology.

Section 4 – Accident & Emergency Medicine (including Minor Injury/Casualty Units and Walk In Centres)

Accident & Emergency Departments

82 The Reference Costs 2006 collection covers all services that fall within the sphere of Accident and Emergency Services. The definitions used are consistent with the full NHS data dictionary definitions which give three types of classification for A&E services.

83 Accident and Emergency services are defined as:

"A type of SERVICE POINT.

These may be either major units, providing a 24 hour service seven days a week to which the great majority of emergency ambulance cases are taken, or small units commonly called casualty departments, in which services are often only available for limited hours and which may not deal with emergency ambulance cases.
A casualty department is not always part of a HOSPITAL SITE.
Additional activities may also take place such as: elective surgical work of a minor nature, observation and treatment of PATIENTS in beds, and the holding of out-patient clinics. Beds either within or adjacent to a department will be counted as a WARD or part of a WARD. Work apart from the accident and emergency service should be recorded in the appropriate data system.

An accident and emergency service offers care to PATIENTS who arrive with urgent problems and who have not usually been seen previously by a GENERAL PRACTITIONER.

In the case of serious illness or accident, the treatment provided will be vital resuscitation only before the PATIENT is admitted to hospital.

Attributes of this entity type are:
ACCIDENT AND EMERGENCY DEPARTMENT TYPE

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

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

84 24 hour manned Accident and Emergency Units, whether single or multi-specialty, are costed using the services specific HRGs currently available.

85 The **casemix adjusted measures (i.e. HRGs) for A&E** were first introduced on a mandatory basis in June 2000. Version 3.2 HRGs were introduced in 2002, supported by a Data Set Change Notice which mandated the necessary data collection. These HRGs **continue to be used for 24 hour manned A&E Departments, thus there is no change in this area from previous submissions.**

86 A&E clinicians continue to review these grouping and it is anticipated that these HRGs will be refined in future years.

87 Situations do occur when patients are brought to A&E Departments by ambulance and despite the best efforts of staff, the patient is Dead on Arrival (DoA). These patients have to be certified as dead by a clinician. These form a distinct category from those patients that die in an A&E Department. These are recorded within the A&E department but do not incur high levels of resource utilisation. These patients need to be recorded within the A&E category, although as a separate activity from HRG related activity. Full details of the HRGs, definitions and DoA category can be found in Appendix 5 of the NHS Costing Manual.

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

88 A high level classification, introduced in 2003, is used for other types of Accident & Emergency Services.

89 Information on the number of attendances and a unit cost per attendance is therefore required for: -

- Non-24-hour A&E Departments / Casualty Departments,
- Discrete Minor Injuries Units, &
- Walk In Centres.

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

91 As with all other services, the full costs of these services should be included. This will include costs of doctors, salaried GPs, as well as the costs of nursing, equipment, support services. etc. No sub-division of patients across presenting symptoms, diagnosis or discharge method is required for these units.

92 In response to changes in clinical practice, discrete Walk In Centres were included in the Reference Costs 2005 collection for the first time. Walk In Centres provide:

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

Cost and activity data continues to be required at first and follow up attendance level. In 2006, no further distinction in activity is made.

Admission / Pre-Admission Wards, Assessment Units, Observation Wards

93 Cost and activity data for these types of wards and units should be reported as detailed in paragraph 40.

Section 5 –Paramedic Services Provided by NHS Ambulance Service Providers

94 These services were introduced into Reference Costs in 2003. The activity and costs included in the collection relate to **incidents** for Emergency (999) calls, Urgent and Emergency High dependency transfers. **Note that the activity data should reflect the activity levels per the annual KA34 ORCON return to the Department of Health;** Incidents should therefore be less than the number of calls shown in line 01 of the KA34 – see also paragraph 95 below. Response data will continue to form part of the Reference Costs collection from an activity requirement perspective only.

95 Patient Transport Services (PTS) provided by NHS Ambulance Trusts, NHS Direct (where appropriate) and air ambulance services continue to be excluded from the Reference Costs return.

96 As in 2005, the basis of activity for Paramedic Services provided by Ambulance NHS Trust is incidents, not responses. This differs from calls, responses and patients. The collection is based on a full year's activity and costs as for other NHS services and will be reported on the same timescales as detailed throughout this guidance.

97 The following should be noted for 'Incidents':

- An incident is an event that results in one or more calls being made to the emergency ambulance service provider.
- For example, five calls re: the same event equals one incident.
- An incident may result in a response by an ambulance resource, e.g. an ambulance, rapid response vehicle, motorbike, etc., or may result in a transfer to other NHS Services, e.g. NHS Direct, etc.
- The number of incidents will be equal to or less than the number of calls received, but may be greater or less than the number of responses.
- For example, the number of incidents will be more than the number of responses where an incident does not result in a response.
- The number of incidents will be less than the number of responses where more than one type of response is issued.
- With regard to 'Major Incidents', where resources are solely dedicated to providing cover for major incidents, these should continue to be reported separately in the Reference Costs collection, using the appropriate category. Where resources are not dedicated to major incidents, they should be included in the composite Category A, B and C return, as appropriate.

98 Similarly, for responses:

- Activity relates to the number of responses activated, including abortive responses.
- Where more than one type of response is issued, e.g. Rapid Response and Ambulance, these will count as two responses.
- Responses include those by Rapid Response Vehicles, Fast Response Vehicles, Paramedic Response Units, Ambulances, Motorbikes, Pushbikes, etc.
- The exception to the above treatment relates to potential or actual major incidents. In these cases, the 'standard' response may be the dispatch of a pre-determined number of personnel and vehicles. For these incidents only, this counts as a single response. If subsequently, additional crews, vehicles, etc., are required, this should be counted as a second, third, etc. response as required.
- Some ambulance service providers may use the term 'activation' for this type of activity.

99 The analysis will cover:

- Incidents of Category A (Red) calls, defined as '*Patients who are or maybe life threatened and will benefit from a timely clinical intervention*', analysed and costed over 32 codes;
- Incidents of Category B (Amber) calls, defined as '*Patients who require urgent face to face clinical attention but are not immediately life threatened*', analysed and costed over 32 codes;
- Incidents of Category C (Green) calls, defined as '*Patients who do not require an immediate or urgent response by blue light and may be suitable for alternative pathways of care*', analysed and costed over 23 codes;

- Other 999 calls analysed and costed across 4 categories;
- Urgents and Emergency Transfers combined.

100 As in 2005, cost and activity data for Category B and Category C incidents are required to be reported separately.

101 Certain classifications are no longer required for Category C. The categories to be used for the analysis of calls have been amended as follows:

Classification Narrative	Cat. A/ Red	Cat. B/ Amber	Cat. C/ Green	MPDS Versions 10 & 11 Code Prefix	CBD Version 4 Code Prefix
▪ 01 Abdominal Pain/Problems; Abdominal / Back Pain	✓	✓	✓	1***	01***
▪ 02 Allergies (reactions)/ Envenomations (stings, bites); Allergic Reaction	✓	✓	✓	2***	02***
▪ 03 Animal Bites/ Attacks	✓	✓	✓	3***	03***
▪ 04 Assault/ Sexual Assault/ Rape; Assault / Trauma	✓	✓	✓	4***	21***
▪ 05 Back Pain (incl. non traumatic)	✓	✓	✓	5***	N/A
▪ 06 Breathing Problems; Breathing Difficulty	✓	✓	✓	6***	05***
▪ 07 Burns/ Explosion	✓	✓	✓	7***	22***
▪ 08 Carbon Monoxide/ Inhalation/ Hazardous Chemical; Environmental Emergency	✓	✓	N/A	8***	10***
▪ 09 Cardiac or Respiratory Arrest/ Death	✓	✓	N/A	9***	06***
▪ 10 Chest Pain	✓	✓	✓	10***	07***
▪ 11 Choking	✓	✓	✓	11***	08***
▪ 12 Convulsions/ Fitting	✓	✓	N/A	12***	11***
▪ 13 Diabetic Problems	✓	✓	✓	13***	09***
▪ 14 Drowning (incl. near)/ Diving/ SCUBA Accident	✓	✓	N/A	14***	23***
▪ 15 Electrocution/ Lightning	✓	✓	N/A	15***	N/A
▪ 16 Eye Problems	✓	✓	✓	16***	N/A
▪ 17 Falls/ Back Injuries (traumatic); Falls/ Accidents	✓	✓	✓	17***	24***
▪ 18 Headache	✓	✓	✓	18***	13*** 25***
▪ 19 Heart Problems/ A.I.C.D.	✓	✓	✓	19***	N/A
▪ 20 Heat / Cold Exposure	✓	✓	✓	20***	N/A
▪ 21 Haemorrhage/ Lacerations; Bleeding	✓	✓	✓	21***	04***
▪ 22 Industrial/ Machinery Accidents	✓	✓	N/A	22***	N/A
▪ 23 Overdose/ Poisoning/ Ingestion	✓	✓	N/A	23***	15***
▪ 24 Pregnancy/ Childbirth/ Miscarriage; Gynaecological	✓	✓	✓	24***	12*** 16***
▪ 25 Psychiatric/ Suicide Attempt; Mental/ Emotional	✓	✓	✓	25***	14***
▪ 26 Sick Person (Specific Diagnosis)	✓	✓	✓	26***	N/A
▪ 27 Stab/ Gunshot Wound	✓	✓	✓	27***	N/A
▪ 28 Stroke/ CVA	✓	✓	N/A	28***	18***
▪ 29 Traffic/ Transportation Accidents; RTAs	✓	✓	N/A	29***	26***
▪ 30 Traumatic Injuries (Specific)	✓	✓	✓	30***	N/A
▪ 31 Unconscious/ Fainting (near)/ Passing Out (non-traumatic)	✓	✓	✓	31***	19***
▪ 32 Unknown Problem (incl. collapse - 3rd party); Sick/ Unknown/ Other	✓	✓	✓	32***	17***

102 The categories to be used in the analysis of other 999 calls are:

- Major incidents / airports
- Out of Hours service (where NHS ambulance provider has taken over the responsibility of providing this service from GPs, and where the service is commissioned by PCTs)
- Transferred for telephone advice
- Unclassified / uncoded
- Other.

103 No further subdivision of the combined urgents and emergency transfers category will be included at this point. The collection files will therefore only include one further category for these types of transfer.

104 The costing of these services should follow the accounting principles and concepts as detailed in the NHS Costing Manual. A separate chapter also appears in the Manual for these services.

105 Note that the costs of activity provided by Emergency Care Practitioners [ECPs] should form part of the composite costs of the Reference Costs submission, in line with the principles of total absorption costing. Statement Z will require costs and activity [WTEs] of ECPs included as part of the submission data.

106 Although changes have been made to the original collection requirements that were introduced in 2003, the process of monitoring and reviewing of the collection requirements, as with all costs and classifications, will continue in future years.
In terms of additional benchmarking opportunities, and whilst incidents remain the agreed reporting requirement for unit costs, activity data for journeys and calls, as well as responses are included in all relevant services areas in 2006. Definitions and activity reported for calls and journeys should be those used for the **KA34 ORCON** return to the Department of Health.

Section 6 – Obstetrics and Maternity Services

107 There are no changes to the requirements of the Reference Cost collection in 2006 with regard to these services.

108 All inpatient and day case activity forms part of the collection for the following:-

501 Obstetrics
560 Midwife Episodes

109 For obstetrics, where a patient passes between consultants as part of a single obstetrics episode the whole costs should continue to be brought together and recorded as one version 3.5 HRG. The activity recorded is the delivery episode in the majority of cases. The number of episodes should not be artificially inflated by the recording of well babies. Where a baby is discharged at the same time as the mother, this is counted as one delivery episode for reference costs purposes (i.e. well babies are not the patient, rather the patient is the mother with a delivery episode).

110 Babies who are unwell and who need additional care and treatment e.g. special care will generate activity in these areas and this should be counted separately and recorded against the relevant services.

111 CNST premiums should be treated as an overhead to the relevant specialty, and then weighted across all patient types and activity to reflect the type of claims that arise. When allocating CNST premiums, it should be noted that maternity services often incur a much higher CNST premium that most other services, to reflect the majority of sizable claims that arise from delivery events. This should be accurately reflected in the relevant cost pool[s] when determining the unit costs of all types of maternity activity. Although the majority of claims arise at the point of actual delivery, causation could be linked to events that happen earlier in the patients' care.

112 Community (home) deliveries also form part of the collection, and these continue to be shown separately from hospital based deliveries. A separate sheet exists within the collection (in the community services file) to ensure that all deliveries are recorded. Non-hospital deliveries form part of the mandatory collection, and steps should be taken to ensure that this information is routinely collected and accessible within comprehensive midwifery records and systems.

113 As in previous years, the cost of epidurals and other forms of pain relief should be included in the cost quantum for these services. They should not be treated as exceptional items. Likewise, routine HIV/Aids tests are offered to mothers and these costs should be treated as an indirect cost to the relevant service area. Such tests are usually carried out via obstetrics outpatients/ante natal clinics.

114 For outpatients, ante-natal care, etc., the service classifications remain consistent with those that formed the 2003 collection requirements. As a general guide, obstetric care is usually provided by consultants, whereas ante-natal care is often directly provided by midwives, under the responsibility of a consultant. In all cases, the information requirements continue, including the application of the 'consultant-responsible' definition when determining total activity levels for clinics.

115 Empirical data indicates that some categories of mother impact significantly in cost terms across the full range of maternity services. To reflect these variations, obstetric and ante-natal care continues to be sub-divided.

116 The four categories retained for use in 2006 are: -

- **Expectant Mothers with Substance Misuse**
  (includes misuse of all forms of drug, alcohol and banned substances, but excludes smoking);
- **Expectant Mothers with Diabetes**
  (includes women with pre-existing diabetes, and those who develop diabetes (including short-term) during their pregnancy);
- **Other High Risk Expectant Mothers**

(includes women with pre-existing conditions which may be impacted upon by pregnancy, e.g. Cardiac Disease, Sickle-Cell Anaemia, Epilepsy, Transplant recipient, severe Asthma, Cystic Fibrosis, etc.)

- **Other Expectant Mothers**
  (includes all other mothers that do not fit into one of the above hierarchical categories).

117 These categories will be used for obstetrics and ante-natal clinics, **irrespective of whether that clinic is held within a hospital or community setting**. This specifically includes community midwifery ante-natal care undertaken in GP surgeries, which should be included as part of ante-natal outpatients.

118 Ante-natal and post-natal visits in the home setting also form part of the collection. Ante-natal and post-natal visits should be recorded, costed and reported separately, as in 2005.

Section 7 – Outpatient Services

119 The 2006 reference costs collection continues to require unit cost and activity information on a first and follow up attendance basis. The specialties and sub-specialties for which this information is required are identified below.

120 It should be noted that both face to face and non-face to face activity is only valid if it directly entails contact with the patient or with a proxy for the patient, such as the parent of a young child. 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.

121 As in 2005, it is necessary to distinguish between activity relating to adults and activity relating to children (up to and including 16). This distinction applies to a number of specialties. In addition, as notified in 2005, outpatient attendance data will be split between face to face and non-face to face activity, for the first time.
The requirement for each specialty / sub-specialty / service will be:-

- Unit cost per attendance and total number of attendances for face to face services;
- Unit cost per contact and total number of contacts for non-face to face services.

122 There is no requirement to record or report activity data at outpatient HRG level, but **the requirement to report cost and activity data for specified procedures undertaken in an outpatient setting has been extended to a greater number of procedures in 2006.** Note that where an outpatient procedure is reported, an outpatient attendance (either first or follow up) cannot also be counted for this same activity.

123 It remains advisable for organisations to continue to record all procedures undertaken in an outpatient setting locally. It is anticipated that the number of procedures that are required to be separately identified and reported in Reference Costs will be extended and refined in future years.

124 A full list of the service areas / specialties / clinic functions to be reported at first and follow up attendance level is shown below. Such outpatient attendance data must also be split between face to face and non-face to face activity per paragraph 121. The 2005 requirement to separately report data by adult / child remains in 2006, indicated by an asterisk (*).Where appropriate, updated national specialties, per those issued in DSCN 34/2003, have been utilised. In addition, specified sub-specialties have been retained for the Reference Costs 2006 collection:

Code	Treatment Function Title/ Other
100	General Surgery*
101	Urology*
102	Transplantation Surgery
103	Breast Surgery*
104	Colorectal Surgery*
105	Hepatobiliary & Pancreatic Surgery*
106	Upper Gastrointestinal Surgery*
107	Vascular Surgery*
110n	Trauma & Orthopaedics: Non-Trauma*
110t	Trauma & Orthopaedics: Trauma*
120	ENT*
130	Ophthalmology*
140	Oral Surgery*
141	Restorative Dentistry
142	Paediatric Dentistry
143	Orthodontics*
144	Maxillo-Facial Surgery*
150	Neurosurgery
160	Plastic Surgery*
161	Burns Care (To be used by recognised specialist services only)*
170	Cardiothoracic Surgery
171	Paediatric Surgery

172 Cardiac Surgery
173 Thoracic Surgery
174 Cardiothoracic Transplantation (To be used by recognised specialist services only)
180 Accident & Emergency
190 Anaesthetics (Not a Treatment Function)
191 Pain Management*
300 General Medicine*
301m Medical Gastroenterology*
301s Surgical Gastroenterology*
302 Endocrinology*
302s Endocrine Surgery*
303 Clinical Haematology*
304 Clinical Physiology (Not a Treatment Function)
305 Clinical Pharmacology
306 Hepatology*
307 Diabetic Medicine*
BMTPT Bone Marrow Transplant- Post Transplantation
BMTO Bone Marrow Transplant- Other
309 Haemophilia
310 Audiological Medicine
311 Clinical Genetics
312 Clinical Cytogenetics and Molecular Genetics (Not a Treatment Function)
313 Clinical Immunology & Allergy
314 Rehabilitation
315 Palliative Medicine
316 Clinical Immunology
317 Allergy
319 Respite Care
320 Cardiology*
321 Paediatric Cardiology
322 Clinical Microbiology*
330 Dermatology*
340 Thoracic Medicine*
341 Sleep Studies*
350 Infectious Diseases
352 Tropical Medicine
360 Genito-Urinary Medicine
361 Nephrology
370 Medical Oncology* (Attendance without Treatment)
400 Neurology
401 Clinical Neuro-Physiology
410 Rheumatology*
420 Paediatrics
421 Paediatric Neurology
422 Neonatology
430 Geriatric Medicine
450 Dental Medicine Specialties
460 Medical Ophthalmology*
502 Gynaecology*
503 Gynaecological Oncology*
560 Midwife Episode
800 Clinical Oncology (Attendance without Treatment)*
821 Blood Transfusion
822 Chemical Pathology
997 Podiatry
999 Other
CSB1A Cystic Fibrosis - Band 1 : Adults
CSB1C Cystic Fibrosis - Band 1 : Children
CSB2A Cystic Fibrosis - Band 2 : Adults
CSB2C Cystic Fibrosis - Band 2 : Children

CSBAA	Cystic Fibrosis - All Other Bands : Adults
CSBAC	Cystic Fibrosis - All Other Bands : Children
DTC	Dietetics
FPC	Family Planning Clinic
H/A	HIV / AIDS
HACC	Anti-Coagulant Clinic
OPT	Orthoptics
SIU	Spinal Injuries (designated units only)
TOTA	Occupational Therapy Clinics – Adult
TOTC	Occupational Therapy Clinics – Child
TPHA	Physiotherapy Clinics – Adult
TPHC	Physiotherapy Clinics – Child
TSLA	Speech & Language Therapy Clinics – Adult
TSLC	Speech & Language Therapy Clinics – Child
MS	Maternity Services Outpatient Attendance Data (separate collection file)
AuS	Audiological Services (separate collection file - Audiology)

125 Where organisations are unable to distinguish between child (up to and including 16) and adult activity in 2006, they should report all outpatient activity and cost data as 'adult', split, as appropriate, between first and follow up attendances. Organisations are advised to ensure that the ability to separately identify child and adult activity in an outpatient setting is available in future years.

126 Where organisations are unable to distinguish between face to face and non-face to face activity, **all** costs for a particular specialty / sub-specialty / service should be reported across face to face activity only.

127 As a general principle, it should be noted that the same patient can access a service as a face to face contact and as a non-face to face contact in the same financial year. A single patient can therefore appear in both categories accessing the same service in two different ways. There is no requirement that stipulates that only those patients that have had a face to face contact can be counted as having subsequent non-face to face contacts in 2005/2006. Although some patients might be reported in both categories, not all would be expected to do so.

Audiological Medicine

128 Note that the costs and activity associated with maintenance and reprogramming after implementation of Cochlear Implants and Bone Anchored Hearing Aids are excluded from Reference Costs in 2006. The costs and activity associated with implanting such devices continues to form part of the admitted patient care return.

Cystic Fibrosis

129 Cystic Fibrosis services were separately identified for the first time in 2003, facilitated by the national specialised service definitions for Cystic Fibrosis. The six categories that formed the 2004 collection have been retained as detailed above.

130 Further details of the requirements for reporting inpatient Cystic Fibrosis data can be found in Section 12 – Specialised Services. The split between children (up to and including 16) and adults is standard for reference costs purposes.

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

- Band 1
  Patients who come only to outpatients, receive outpatient care in terms of input from physiotherapist, doctors, social workers, dieticians, etc.
- Band 2
  Patients who receive the above and in addition receive outpatient intravenous antibiotics 3-4 times a year. They may be occasionally admitted. The input as an outpatient may be more intense.

HIV / Aids

132 Detailed costing of these services has already been undertaken in the NHS as part of previous reviews of funding. The introduction of a separate analysis of these services in 2001 built on this work. There is no change in approach for services provided to patients with a secondary diagnosis of HIV/Aids.

133 The costs associated with outpatient services need to be separately identified - treatments associated with combination drug therapy for example, need to be directly attributed to these services to prevent distortions elsewhere. A separate category within outpatients was introduced in 2001 and will continue to be collected in the same format. Cost and total attendance data should be reported using the follow up attendance category only, to protect patient confidentiality.

Orthoptics

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

Radiotherapy

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

Therapy Services / Dietetics

136 In response to feedback from the NHS, new outpatient categories were introduced in 2005 for Occupational Therapy, Physiotherapy and Speech and Language Therapy attendances at outpatient clinics. These are to be used in instances where referral for treatment carried out in a hospital setting has been made by a clinical / other professional, including a GP, or self-referral, and where the patient attends a discrete therapy clinic solely for the purpose of receiving therapy treatment. Referrals by GPs to such clinic-based services no longer need to be separately reported as direct access therapy services, which has been withdrawn from the 2006 collection (Section 13 clarifies).

137 As with other types of support services and care, where these services form part of an inpatient/day case episode, their costs are included as part of the overall treatment cost. Similarly, where the treatment is included as part of an outpatient attendance, in a separate specialty, the costs will form part of the composite costs of that outpatient attendance.

138 The split between children (up to and including 16) and adults is standard for reference costs purposes.

139 The costing methodology used for such clinics must follow costing principles as laid out in the Costing Manual, and paragraphs 136 – 137 of this document.

140 Note that details regarding the number and total cost of clinics run on a group basis will be required for Statement Z in 2006.

141 The 2006 collection introduces the category of Dietetics into the outpatient collection, where patients attend a dietetic clinic solely for the purpose of dietetic treatment. Referrals by GPs to such clinic-based services no longer need to be separately reported as direct access dietetics, which has been withdrawn from the 2006 collection (Section 13 clarifies).

Outpatient Procedures

142 An extended list of the outpatient procedures to be separately identified and reported in Reference Costs is shown below. There is no requirement to split procedure activity between child and adult in this first instance, nor to distinguish between procedures carried out in a first attendance, and those carried out at a follow up attendance.
Note that where an outpatient procedure is reported, an outpatient attendance (either first or follow up) cannot also be counted for this same activity.

OP Procedure Code	Procedure Narrative
OPAIJ1	Aspiration / Injection into Joint
OPANG1	Angiography
OPAPT1	Apicectomy of Tooth
OPBCU1	Biopsy of Cervix Uteri
OPBCY1	Bronchoscopy
OPBVV1	Biopsy of Vulva
OPCAR1	Carpal Tunnel Release
OPCON1	Colonoscopy
OPCOP1	Colposcopy
OPCRT1	Cataract Replacement
OPCYY1	Cystoscopy
OPDEL1	Diagnostic Endoscopic Examination of Larynx
OPDEP1	Diagnostic Endoscopic Examination of Pharynx
OPDMA1	Drainage of Middle Ear
OPEPI1	Epidural Injections (for Pain Services, specifically not to be used for Obstetrics)
OPFNB1	Fine needle biopsy of breast
OPFSI1	Flexible Sigmoidoscopy
OPHYS1	Hysteroscopy
OPLDL1	Laser Destruction of Lesion of Skin
OPMTM1	Medical Termination
OPNBP1	Needle biopsy of prostate
OPRSI1	Rigid Sigmoidoscopy
OPSIS1	Subcutaneous injection / introduction of substance into skin
OPSRT1	Surgical Removal of Tooth
OPUDS1	Urodynamic Studies
OPUGE1	Upper Gastro Endoscopy

144 Where organisations are unable to separately identify procedures undertaken in an outpatient setting, they should report all outpatient activity data using first and follow up attendance categories, split between adult and child, and face-to-face / non-face to face, as appropriate. Organisations are advised to ensure that the ability to separately identify procedures undertaken in an outpatient setting is available in future years.

145 A list of OPCS codes that map to the procedures in paragraph 142 are available in Appendix 6 of this document, to aid consistency in data reporting.

Activity and Costing DN: HAS BEEN EXTENDED IN LINE WITH FAQ – WILL IT WORK?

146 Outpatient clinics have previously related to those clinics with pre-booked appointments for which a consultant is clinically responsible whether they are present at the clinic or not.

147 The above definition may not capture all types of appropriate activity, especially where changes in service provision and delivery mean that services are provided in a variety of ways, and by a variety of clinical and medical staff. Thus for 2006, where a patient sees a health care professional in a clinic setting, for which the patient has an appointment, and that patient receives healthcare treatment,

including a clinical consultation, such activity can be counted as valid outpatient activity. Note that healthcare professionals are those that provide clinical or medical treatment and are employed by an NHS provider.
Where a patient attending a clinic sees more that 1 healthcare professional at that clinic during their attendance, the patient attendance should be counted only once.

148 All such clinics are included in the exercise where the activity, costs and income are counted against the service agreement with the NHS provider. This includes clinics held in a variety of locations and not just those held within main hospital sites, thereby including GP practice premises.
Where a clinician or nurse holds outpatient clinics whilst acting in a private capacity, these are not recorded against the NHS organisations activity and cost base and therefore are excluded from the exercise from a provider perspective. The same 'rules' apply to outpatient clinics held by a clinician or other primary care practitioner as part of the plus element of a PMS contract.

149 The standard approach to the costing of outpatient activity remains unchanged. When producing unit attendance costs at specialty, sub-specialty or service level, the costs of investigations, tests, drugs or other care e.g. physiotherapy, should be included **at the point of commitment, up to the point where the patient accesses another service that is separately identified in the Reference Costs collection**. At this time, the costs and activity should be reported using the appropriate currency for that (new) service area. Examples include:-

- An outpatient Radiology Examination requested as an outpatient but performed during a following IP Episode counting as part of the Inpatient Episode and not the previous Outpatient Attendance;
- A patient attending an outpatient clinic, followed by six physiotherapy attendances, (in a discrete physiotherapy clinic, where the patient attends solely for the purpose of receiving physiotherapy treatment) before a follow up outpatient appointment reported as two outpatient attendances (first and follow up in relevant specialty), and six physiotherapy attendances in the outpatient physiotherapy category.

150 More detailed guidance on the costing of outpatient services can be found in Chapter 5 of the NHS Costing Manual.

Alternative Service Delivery

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

152 Where services provided by these practitioners are discrete services / clinics, e.g. aromatherapy, massage, acupuncture, homeopathy, **these services continue to be excluded in 2006**.

Mental Health

153 Details on the costing of Mental Health outpatient and community appointments can be found in Section 8 of this guidance.

Section 8 – Mental Health Services

Inpatient Services

154 The requirement for the reporting of Mental Health inpatient services remains unchanged from those for the 2005 collection. Changes have been made to booked appointments.

155 The 2001 collection introduced inpatient stays on an occupied bed day basis. A particular feature of admitted inpatient care for Mental Health Services is the use of 'leave', sometimes referred to as 'home leave', in the treatment of patients. Some admitted inpatients are 'sent on leave' to return at a future date. They are not discharged, however their beds are used for other admitted patients. To include these 'sent on leave' days as activity in Reference Costs for these services serves to increase occupancy levels to more than 100%, and effectively dilute the cost per occupied bed day.
In a clarification of the counting treatment for patients on home leave, therefore, organisations should ensure that **the reported total number of occupied bed days does not include any element of 'leave' day activity, unless a bed is retained solely for use by the patient on leave, and is not filled in their absence.** This will ensure that the activity reported as part of Reference Costs for Mental Health inpatient services will never exceed 100% occupancy, and that reported total unit costs per occupied bed day will reflect the actual costs incurred by an NHS provider per occupied bed day.

156 These services are further sub-divided based on the age of the patient into distinct bandings for the care of adults, children and the elderly. In addition, the former is split between Acute, Intensive and Rehabilitative care. This is consistent with the approach adopted by the National Service Framework for mental health services.

Inpatient Services – Secure Units

157 Secure units have been included in reference costs since 2002. For consistency, the unit cost and activity information is based on occupied bed day data. As with other elements of mental health services, the service mapping definitions should continue to be used for:-

- Local Psychiatric Intensive Care Units
- Low Secure Services
- Medium Secure Services
- High Dependency Secure Provision
- Maximum Secure Units (to be used by three designated units only; Broadmoor, Rampton and Ashworth).
- Child & Adolescent Low Secure Services [three designated units only – see para. 158]
- Child & Adolescent Medium Secure Services [three designated units only – see para. 158]
- Child & Adolescent High Secure Services [three designated units only – see para. 158].

158 Based on feedback from NHS providers of High and Maximum Secure Unit Services, refinements were included for this group of specialist units in 2003. These refinements continue to form part of the 2006 collection. Activity is thus required on an occupied bed day basis, split over five clinical groups: -

- Women's Services
- Mental Health/Psychosis
- Learning Disabilities
- Personality Disorder &
- Dangerous and Severe Personality Disorder [for Maximum Secure Units only].

159 The three designated units that are required to submit data for Child and Adolescent Secure Services are:

I) Newcastle,
II) Birmingham
III) Salford

Inpatient Services – Specialist Services

160 In addition, the specialist services introduced in 2002, are retained in 2006. Unit cost and activity data is based on occupied bed days.

- Autistic Spectrum Disorder
- Eating Disorder Services (sub-divided between services for children and adults)
- Mother and Baby Units (the service definition included in the service mapping exercise should be applied here).

161 The inclusion of these services brings the majority of costs for mental health inpatient services into the collection. Work is still ongoing to develop costing for psychological therapy services, day unit / hospital services, and support services such as self-help and advocacy schemes.

Outpatient and Community Services

162 As in 2005, the 2006 collection requires outpatient and community services data to be identified and separately reported.

163 The key to determining which elements are included is governed by the existence of a "booked appointment".

- If a patient has a booked appointment, in a **clinic**, held on NHS premises, including GP Practices, it should be included in the outpatient category;
- If a patient has a booked appointment in a community setting, including the patient's home, it should be reported using the community category.

164 In addition, these services for adults continue to be sub-divided further, to provide separate activity and cost data for drug and alcohol services and other types of outpatients. The split between drug and alcohol and other types of outpatients will be retained for mental health services provided to children. Costs and activity relating to Methadone Swallow and Depot Injection Clinics continue to be excluded from the Reference Costs 2006 collection.

165 Due to the particular nature of mental health services, DNAs (did not attends) utilise considerable mental health resources, therefore outpatient activity for mental health services requires DNA activity to be identified and reported separately as a memorandum item on the relevant collection file. There is no requirement to submit unit cost data for DNAs. This means that:

- The total cost of a specific outpatient service, calculated using total absorption costing methodology should be identified, for each category of collection, for each of first and follow up outpatient attendances in mental health.
- Activity for the total number of face to face attendances for each of first and follow up attendances should be identified.
- Unit cost for each type of attendance should be calculated by dividing total cost by the total number of face to face attendances for each of first and follow up attendances.
- In addition, total number of DNAs for each of first and follow up attendances should be reported as a memorandum item. This activity must not be included in the total face to face activity reported, nor in the calculation of the unit cost per face to face attendance, as to do so would inappropriately dilute the reported unit costs.

166 The collection for first attendance outpatient mental health services will therefore resemble the following:

Code	Narrative	Unit cost per Face to Face First Attendance £	Total No. of Face to Face First Attendances	Total No. of DNAs for Face to Face First Attendances
MHOPFAA1	Adult: Drug & Alcohol Services			
MHOPFAA2	Adult: Other Services			
MHOPFAC1	Child: Drug & Alcohol Services			
MHOPFAC2	Child: Other Services			
MHOPFAE1	Elderly Services			

167 Note that the above information will also be required for outpatient follow up attendance data. DNA memorandum data is required for such activity in a community setting on Statement Z only.

168 As in previous years, non-face to face activity is not valid for inclusion in mental health services data.

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

Outpatient and Community Services – Specialist Services

170 As with non-specialist mental health services, the 2006 collection will require outpatient and community services data to be identified and separately reported. The collection categories as detailed below are retained.

- Autistic Spectrum Disorder
- Eating Disorder Services (sub-divided between services for children and adults)
- Mother and Baby Units (the service definition included in the service mapping exercise should be applied here).

171 For each of the specialist services identified above, data should be provided in line with the illustrative table in paragraph 166. First and follow up attendance data will be reported separately, and DNA activity will form part of the memorandum information on this collection file. Community based services will be reported separately, with the DNA memorandum data required on Statement Z only.

172 The community-based services collection for Specialist Services follow up attendances will therefore resemble the following:

Code	Narrative	Unit cost per Community-based Face to Face Follow Up Attendance £	Total No. of Community-based Face to Face Follow Up Attendances
MHCYSSFUASD	Autistic Spectrum Disorder		
MHCYSSFUEDA	Eating Disorder Services: Adult		
MHCYSSFUEDC	Eating Disorder Services: Child		
MHCYSSFUMBU	Mother & Baby Units		

173 Note that the above information will also be required for community-based first attendance data. DNA memorandum data is required on the collection file for such activity in an outpatient setting.

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

Mental Health Specialist Teams

175 As in 2005, the 2006 collection requires separate unit cost and activity data to be reported for a variety of services undertaken by mental health specialist teams. The categories that will form part of this collection are based on those used in the financial mapping LIT collection. This is in order to utilise information that is already reported to the Department of Health by mental health services providers.

176 They are identified as follows (references in brackets refer to Financial Mapping Lit collection guidance and definitions):-

- Community Mental Health Teams (Line 17)
  Access & Crisis Services;-
- Crisis Resolution Home Treatment Teams (Line 20)
- Assertive Outreach Teams (Line 21)
- Early Intervention in Psychosis Services (Line 22)
- Homeless Mental Health Services (Line 23)
- A&E Mental Health Liaison Services (Line 25)
- Crisis Intervention Services (Line 26)
- ASW Services (where NHS Funded) (Line 28)
- Emergency Duty Teams (Line 29)
- Other Mental Health Specialist Teams : Adult [to be used where no LIT mapping information is available]
- Other Mental Health Specialist Teams : Child [to be used where no LIT mapping information is available]
- Other Mental Health Specialist Teams : Elderly [to be used where no LIT mapping information is available]

177 In all instances, the unit cost of a face to face team contact, and the total number of face to face team contacts should be reported. Note that face to face team contacts are those with the patient, rather than face to face contacts with personnel about the patient. Also note that DNAs are not valid activity for this area of the collection, nor will such activity form part of the collection requirements.

178 Data reported should be reconciled to the categories used in the Lit return. As this return presently covers only adult activity, two new categories have been introduced in 2006, for services targeted specifically at children, and the elderly, thus:

- Services provided to children should be reported within the composite costs and activity of each relevant category, where possible. Where services provided to children cannot be identified by Lit category, the 'Other Mental Health Specialist Teams : Child' category should be used for all costs and activity relating to specialist mental health teams dealing with patients up to and including 16 years old.
- Services provided to the elderly should be reported within the composite costs and activity of each relevant category, where possible. Where services provided to the elderly cannot be identified by Lit category, the 'Other Mental Health Specialist Teams : Elderly' category should be used for all costs and activity relating to specialist mental health teams dealing with elderly patients.

179 Note that where a patient receives treatments as if a child, adult or elderly patient, costs and activity of such treatment should be reported in the relevant category, irrespective of whether the patient is technically classed as a child [up to and including 16 years old], an adult, or an elderly patient.

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

Domiciliary Visits

181 Domiciliary Visits by consultant psychiatrists and psychologists, which result in a separate fee being paid, should be shown separately in 2005, as in previous collections. The unit costs should reflect the **true and full cost of these visits** e.g. travel, drugs and an appropriate share of overheads etc and not just salary costs or the actual fee (payment) given.

Regular Attendances at Day Care Facilities

182 A range of services are provided through NHS day hospitals/centres/units. Primarily these provide services for the elderly and rehabilitation services as well as mental health and learning disability patients. Often patients attend these hospitals/centres for a number of days each week and the number of attendances per patient will vary due to the different nature of the patient's condition. Generally the number of places each day is fixed e.g. 20 patients each day and over 5 days this gives 100 patient days. Likewise if a patient attends one day per week for 26 weeks this equates to 26 patient days.

183 There has been some inconsistency in reference costs to date with some providers including these services in the collection and others omitting them in both activity and cost terms. From 2003 onwards, the costs and activity for these day hospitals/centres/units formed part of the collection for elderly, stroke, and mental health services. Centres catering primarily for the long term physical disabled and learning disability patients are still excluded (as all other services for these patient categories are also excluded).

184 Discussions have identified that little patient specific information is routinely recorded for patients attending these units/hospitals. However, in an attempt to try to distinguish categories for reporting mental health day care facilities, the 2006 collection subdivides the single category of previous years into three, 1 for each of:

- Child;
- Adult; &
- Elderly.

Where data is unavailable to enable separate reporting by patient age, all activity and costs should be reported as 'adult'. The basis for inclusion will remain as the total number of patient days and a unit cost per day, for each category.

185 Although it is acknowledged that a range of services/interventions can take place during each day, and this is determined by each patient's condition, this development is seen as being the first stage in introducing these services into the reference costs collection.

186 Note that any additional costs that are incurred when an inpatient concurrently attends a day care facility (and where their bed is not filled, but is retained for their later use) should be removed from the total cost of the day care facility and be reported as part of the composite cost of that inpatient occupied bed day. No day care facility activity should be counted for such patients.
This ensures that the:

- Reported costs of inpatients (on an occupied bed day basis) are fully reflective of the costs incurred by such patients;
- Inpatient is not double-counted in activity terms (e.g. as an inpatient occupied bed day and a day care facility attendance)

- Costs of the day care facility are not overstated.

Thus:

- The total cost of the day care facility must therefore reflect the total cost of the service, less those costs that relate to inpatients attending the day care facility.
- The total activity of the day care facility must therefore reflect the total activity of the day care facility, less the activity relating to those patients who attend but are also currently admitted to that NHS provider as an inpatient.
- Dividing this adjusted total cost by the adjusted activity will produce an appropriate unit cost per patient day for the day care facility.

The above principle also applies to Mental Health inpatients that attend outpatient clinics whilst being an admitted inpatient (adjust cost and ensure activity is not double-counted). Thus, no outpatient activity should be counted for admitted inpatients.
In certain circumstances, it may be applicable to non-mental health Elderly day care facilities, where treatment is similar.

187 In the preparation of cost and activity data for these services, the service definitions included in the Mental Health Service mapping exercise should be used. These can be found on http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/MentalHealthGeneralInfo/fs/en?CONTENT_ID=4077028&chk=kEaoks and in Chapter 8 of the NHS Costing Manual. Changes to the Specialist Mental Health Teams collection is an initial move towards bringing the financial mapping exercise and reference costs closer together where this is feasible.

188 Work continues to bring Mental Health services into the scope of PbR. Increased refinement and the extension of the services included can be expected in the future. Full details of the collection for these services can be found in Appendix 8 of the NHS Costing Manual.

Section 9 – Audiology Services

189 Outpatient clinics for audiological medicine are currently identified separately and this will continue. The revised definition of 'consultant – responsible' clinics permits the inclusion of outpatient attendances and hearing tests conducted by audiologists and audiological technicians where this is not a discrete service.

190 As well as hearing tests, a range of other services are provided through audiology departments. The range of services included in reference costs 2004 is maintained in 2006, without modification.

191 The range of services relating to hearing aids and neonatal screening that form part of the mandatory collection are identified as follows: -

- Hearing Aids
- Fitting of hearing aids & counselling (including those issued for tinnitus);
- Repair Services; &
- Neonatal Screening;

192 Four categories of fitting of hearing aids form part of the 2006 collection: -

- Assessments (including hearing tests);
- Fitting of hearing aid (initial fitting of new or replacement aid, including counselling); &
- Follow up attendances (including counselling).
- Counselling and Issue of Aids for Tinnitus.

193 The classification for counselling and issue of aids for tinnitus now forms part of the overall hearing aid service provision. It covers the issue of white noise generators, pillow maskers, etc.

194 As in 2005, the activity requirement for the fitting of hearing aids is the **attendance**. The requirement will therefore be a unit cost per attendance and total number of attendances for each category.

195 The activity base for repair services will continue to be number of repairs, with a single repair service category of:-

- Hearing Aid Repairs (including postal, patient attendance and "drop off").

196 No differentiation for the above services is made between adults and children.

197 The cost of the hearing aids issued will continue to be separately identified. Costs of other repairs, moulds, tubes etc. should be included as an integral cost driver of the services above.

198 It is recognised that new hearing aids are not issued solely to new patients and that new stronger aids may be required as a patient's hearing deteriorates, or a fault occurs which requires a new aid. It is **not** necessary to differentiate between hearing aids issued between these differing categories of patients. It is expected that more detailed cost and activity information will be developed in the future linked to client groups, and the provision of associated services such as counselling for patients.

199 For hearing aids issued in a given financial year, a unit cost per aid and the total number of aids issued is required for the following classifications of analogue aid:

- Standard Aids
- Superior Aids (including Directional control)

As in 2005, the Digital Hearing Aid Service remains excluded from the 2006 Reference Costs collection, thus the costs of the entire digital hearing aid service (including any capital charges) should be excluded. This guidance applies equally to NHS Foundation Trusts, irrespective of the fact that they do not classify digital aids as fixed assets in their accounts. The situation will be reviewed in future years, and digital hearing aids may be reinstated in the Reference Costs collection, in line with changes in their accounting treatment.

200 Neo-natal screening continues to form part of the mandatory collection requirements in 2006. This service is reported on the basis of number of neonates screened and a corresponding unit cost.

201 To summarise, submissions for audiology services should reflect the following categories:

- Audiological Services return (i.e. fitting of hearing aids, normal & tinnitus; costs of non-digital hearing aids; neonatal screening; repair services);
- Digital hearing aids - costs of entire service to be excluded;
- Audiology activity done as part of ENT outpatient appointments or referrals from ENT outpatient appointments - include costs within the ENT Outpatient costs;
- Audiology activity done via referrals from GPs – report as Audiology Outpatient clinics under specialty 310 on the Outpatient return.

Section 10 – Therapy Services (Community-based Services)

202 This section covers Physiotherapy, Occupational Therapy, and Speech and Language Therapy Services, undertaken in the community. For details of the Therapy Services outpatients categories introduced in 2005, see Section 7.

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

204 Feedback from the NHS has indicated that 'direct access' to such services may be direct access to hospital-based services, or direct access to community-based services. To clarify service definitions;

- Therapy services which are accessed directly by a patient:, and where that patient attends a clinic, with a booked appointment, solely for the purpose of receiving therapy treatment, should be reported as outpatient activity within the relevant therapy category and attendance type (first / follow up, adult / child).
- Therapy services delivered in a community setting should be reported as such, irrespective of the source of referral, using the relevant category.

205 Community based services are therefore those delivered outside a main hospital site, where treatment is not delivered in a clinic setting, but where the intention is to see a single patient in a specific setting. They may be delivered by community based staff or on an outreach basis. The services may, but not exclusively, be follow-on treatments from earlier events, or relate to continuing care in community settings. In 2006, services reported as community should include direct access / referral to services provided in a community setting.

206 Following feedback from the NHS, the number of categories required for community-based therapy services has been extended in 2006, to better reflect the treatment that patients receive. Thus for each service, four categories will form the basis of cost and activity analysis for reference costs 2006. These are: -

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

207 As a result of feedback from the NHS, and the future requirements of PbR, the activity currency for these services changed in 2005. For each category in therapy services, data must be reported for the **total number of contacts in a financial year (not first contacts)** and a unit cost per contact. This will ensure that reported unit cost differences can be related to the differing costs of similar clinical practice, rather than differences in the average number of contacts that a patient has within a particular course of treatment.

208 Where a therapist provides group sessions, each group contact should be counted as **one** 'group services' contact in the financial year. This is irrespective of the size of the group involved.

209 No attempt is made in the 2006 collection to differentiate between patient casemix, other than that associated with age. It is anticipated that in future collections, casemix will be reflected in the collection categories used for these services.

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

211 To reiterate, in 2006, therapy services will be:-

- Reported as part of the composite inpatient cost where they are provided during an inpatient stay;
- Reported as part of the composite outpatient cost where they are provided during an outpatient attendance (see paragraph 136 for clarification);
- Reported as outpatient therapy services where treatment is carried out in a clinic setting, where the patient attends solely for therapy treatment, on a booked appointment basis, irrespective of the source of referral for that patient;
- Reported as community-based therapy services where treatment is carried out in a community setting, irrespective of the source of referral for that patient (GP or otherwise). (See Section 14 for further details).

Section 11 – Community-based / Outreach Specialist Nursing, Other Community Nursing, Health Visitor & Community Medical Services

212 This categorisation includes community-based nursing services provided by Primary Care Trusts and other providers of community-based services. In addition, it also includes specialised nursing services provided by hospital-based staff, who provide on-going care for some patient groups outside the hospital setting. This guidance includes these services and refers to them as 'Outreach' services.

213 It is acceptable for organisations to use sample data to ascertain annual activity for all services identified within this section of the guidance, providing they are appropriate and reflective samples. This is in response to the anticipated volume of data involved, and the paucity of automated recording systems for the majority of community-based and outreach specialist and non-specialist nursing and community medical services. There is no minimum sample time stipulated within Reference Costs; rather, the sample should be reflective of annual activity undertaken within a service area. Where this is not feasible, organisations may use informed clinical estimates if necessary, although it is advisable to retain hard copy evidence of the data source.

214 The range of services provided by these staff continues to grow, and the way in which these services are delivered continues to adapt to reflect changes in clinical practice. The list of services covered in the 2006 collection is unchanged from that used in 2005. In a change to previous years' guidance, the activity currency for the majority of these services will be **total contacts in a financial year**.

215 The 2004 collection introduced a sub-division for **all specialist nursing services and some community nursing services, between face-to-face and non-face-to-face activity**. Although data reported in 2004 appeared inconclusive as to the success of the introduction of non-face to face activity into reference costs, it was decided to retain this facet of the collection in 2005. Data submitted in 2005 has shown a considerable uptake in the reporting of this activity, especially by Primary Care Trusts. **Thus the activity split between face to face and non-face to face activity remains in 2006, but continues to be on an optional basis.** Organisations unable to provide activity data split between face to face and non-face to face totals contacts in the financial year, where applicable, should therefore report all costs for a particular service across face to face activity only.

216 It should be noted that both face to face and non-face to face activity is only valid if it directly entails contact with the patient or with a proxy for the patient, such as the parent of a young child. 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.

217 As a general principle, it should be noted that the same patient can access a service as a face to face contact and as a non-face to face contact in the same financial year. A single patient can therefore appear in both categories accessing the same service in two different ways. There is no requirement that stipulates that only those patients that have had a face to face contact can be counted as having subsequent non-face to face contacts in 2005/2006. Although some patients might be reported in both categories, not all would be expected to do so.

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

219 The rest of this section relates to: -

- Specialist Nursing Services
- Nursing Services for Children
- District Nursing Services
- Health Visiting Services
- School Based Health Services

Guidance for community midwifery can be found in Section 6, for therapy services in Section 10, and for other community based services, e.g. Dietetics, Chiropody, etc., in Sections 13 and 16.

Note that family planning clinics are included within reference costs as outpatients, (code FPC) and should be reported at first and follow up attendance level, regardless of the physical setting of the clinic. They can therefore be found on the outpatient collection file. Additional information can be found in Section 7 of this document.

Specialist Nursing Services :

220 The list of specialist nursing service categories remains largely unchanged from the 2005 collection. The full list is therefore: -

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

221 As stated above, aggregate data needs to be supplied for both community-based nursing staff and hospital-based nursing staff providing on-going care outside the hospital setting.

222 Continence services includes all recipients of these services i.e. those in regular receipt of supplies as well as those being attended by these nurses. All patients in receipt of supplies rather than being attended by a specialist nurse should be reported as non-face to face activity. (See paragraph 215 for further details). This approach also applies to Band 5 Stoma Care.

223 The age split used in 2005 has been retained. For each of the categories listed in paragraph 220, therefore, data is required split by age between: -

- Children (up to and including 16 years old); &
- Adult (over 16).

224 For specialist nursing services particularly, an increasing amount of interaction with patients is via telephone, e.g. for advice and support, rather than on a face-to-face basis. In some cases, the vast majority of patient interaction is on a 'remote' basis, i.e. non-face-to-face.

225 It is acknowledged that the move to telephone-based patient interaction is a growing trend, and to integrate this activity and cost with face-to-face data would be inappropriate, and could lead to distortion in the data reported. As in 2005, in 2006, cost and activity data for all areas of specialist nursing services outlined in paragraph 220 is sub-divided further between:-

- No. of total face-to-face contacts in the financial year

- No. of non-face-to-face total contacts in the financial year (optional requirement – paragraph 215 refers).

226 In summary, the collection for a single category of specialist nursing will be sub-divided across the four sub-sets of : -

- Band 1 – Cancer related : Adult : Face to Face Total Contacts
- Band 1 – Cancer related : Adult : Non-Face to Face Total Contacts
- Band 1 – Cancer related : Child : Face to Face Total Contacts
- Band 1 – Cancer related : Child : Non-Face to Face Total Contacts

These sub-divisions will apply to all categories of specialist nursing.

Nursing Services for Children

227 In addition to the specialist nursing services above, the NHS provides a range of other nursing services for children.

228 Nursing Services for Children exclude the specialist nursing services detailed in paragraphs 220-226 above. It includes the following elements: -

- Judicial System 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.

229 With regard to child protection services, the following should be noted:-

- In general, the cost of child protection is an oncost of Nursing Services for Children. Activity included should relate to the number of total face to face contacts in a given financial year, not the number of children on the register.
  Where funding is received from non-NHS sources / other agencies to help with the costs of funding this post / service, it is valid to nett off such income from the expenditure incurred, in line with the Matching Principle.
- Where there is a discrete child protection service that does not have contact with children, but rather is an advisory service to other elements of health care, these costs should be apportioned between the service areas that receive its advice.
  Where the child protection service offers advice to non-NHS bodies, e.g. social services / the police, etc., these elements of cost can rightly be excluded.

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

230 Although a number of separate elements are identified as composing these services, total contacts in the financial year and unit costs will be reported for all these services as one composite group.

School Based Children's Health Services

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

232 In costing these school based services therefore, it is required that the full cost of delivering these services, not just associated nursing costs, should be included. School-based Children's Health Services include all services provided in the school setting, and not just those nurses that are school-based and providing health services. Details on the reporting of other community medical services can be found in paragraphs 249-254 below.

233 Unlike Nursing Services for Children, school based services are sub-divided for reference costs purposes. Separate reporting is required for: -

- Vaccination Programmes (includes Vaccination Programmes such as MMR, Tuberculosis and Meningitis).
- Other services (includes routine medical checks, sexual health advice, family planning, smoking cessation, substance abuse advice & support, etc.).

234 In reporting terms, the activity measure for vaccination programmes is the number of vaccinations given and a cost per child. The unit cost will include all costs (including administration, nursing and medical costs), and not just the cost of vaccines where these are part of the service costs.

235 Vaccination programmes that are jointly funded by non-NHS providers (including GPs) should not be reported in Reference Costs 2006, as such unit costs are not calculated on a total absorption costing basis and thus may distort national averages. Similarly, where a GP provides the vaccination, but it is administered by a School Based Nurse, the costs incurred by the NHS provider for this element of service (including administration, nursing and medical costs, and appropriate oncosts) should be **excluded** from Reference Costs, as should all associated activity.

236 For all other elements of these services, reporting is based on total number of contacts in the financial year and a unit cost per contact in the financial year. In response to feedback from the NHS, the 'other services' category was subdivided into 'one-to-one services' and 'group services' in 2005, the introduction of the latter category allowing organisations to separately cost and report group activity. This requirement will be retained in 2006. Note that where a school-based practitioner provides group sessions, each group contact should be counted as **one** 'group services' contact in the financial year. This is irrespective of the size of the group involved, which may be a class, a specific year, or the whole school.

District Nursing Services

237 The full classification of services included in District Nursing can be found in Chapter 7 of the NHS Costing Manual.

238 For these nursing services (as with Specialist Nursing Services), a great deal of interaction is increasingly via telephone, i.e. advice, rather than at face to face level.

239 As detailed in paragraph 215, the separate (optional) category for non-face-to-face contacts is retained for 2006, as is the split between services delivered to Children and those delivered to Adults.

240 Thus the 2006 collection for District Nursing Services remains sub-divided across the four sub-sets of : -

- District Nursing Services : Adult : Face to Face Total Contacts
- District Nursing Services : Adult : Non-Face to Face Total Contacts
- District Nursing Services : Child : Face to Face Total Contacts
- District Nursing Services : Child : Non-Face to Face Total Contacts

Health Visiting Services

241 Health Visiting services were reviewed from a reference costs perspective in 2002. In 2006, the levels of service reported remain as: -

- Vaccinations and Immunisations (number of vaccinations given)
- Post-Natal Visits (number of visits)
- Other Health Visiting Services (split between face to face and (optional) non-face to face total contacts in the financial year, as with Specialist Nursing and District Nursing

services, with face to face contacts sub-divided into 'one-to-one services' and 'group services' as with School-based Children's Health Services).

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

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

244 Vaccination programmes that are jointly funded by non-NHS providers (including GPs) should not be reported in Reference Costs 2006, as such unit costs are not calculated on a total absorption costing basis and thus may distort national averages. Similarly, where a GP provides the vaccination, but it is administered by a Health Visitor, the costs incurred by the NHS provider for this element of service (including administration, nursing and medical costs, and appropriate oncosts) should be **excluded** from Reference Costs, as should all associated activity.

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

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

- Post natal visits are those visits undertaken **up to 28 days after the birth**.
- The collection currency for post natal visits for health visitors is the visit itself. From a Reference Cost perspective, therefore it does not matter whether the health visitor sees the mother, baby or both, as the activity counted is the visit itself.
- Visits should only be counted where the patient was seen. Costing and counting treatment should follow the principle used for 'did not attends' (DNAs) in a clinic setting, where the cost of these are an oncost on the service itself, and the activity is not counted.

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

248 In response to feedback from the NHS and in acknowledgement of changes to service delivery, the 'other services' category continues to be subdivided into 'one-to-one services' and 'group services' in 2006. Where a Health Visitor provides group sessions, each group contact should be counted as **one** 'group services' contact in the financial year. This is irrespective of the size of the group involved, or the age range of the group participants.

Community Medical Services

249 As with other community-based staff, community physicians, etc., provide a range of services. This guidance has already identified the activity and cost elements of these services in relation to vaccination programmes through schools.

250 In addition to these vaccination programmes, community physicians also undertake other vaccination work and advice, e.g. travel clinics. However, there is no requirement in 2006 to distinguish between vaccination programmes and other types of vaccination services. The reporting requirements are therefore a single unit cost per vaccination and a total number of vaccinations for all vaccinations and immunisations carried out by all community physicians, including community paediatricians, irrespective of whether these are part of a programme, or delivered as an ad hoc service.

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

252 Vaccination programmes that are jointly funded by non-NHS providers (including GPs) should not be reported in Reference Costs 2006, as such unit costs are not calculated on a total absorption costing basis and thus may distort national averages. The costs incurred by the NHS provider for this element of service (including administration, nursing and medical costs, and appropriate oncosts) should be **excluded** from Reference Costs, as should all associated activity.

253 All other (non-vaccination / immunisation) services are to be reported in aggregate form using total contacts in the financial year as the collection currency. There is no requirement to separately identify community medical services that are provided to a group. In a change to 2005, however, the activity undertaken by community paediatricians is required to be separately identified in 2006, thus the collection categories for 'Community Medical Services: Other Services' will be as follows:-

Code	Label	£ Unit Cost / Contact in Financial Year	No. of Total Contacts in Financial Year
CM45	All Other Services [excluding those provided by a Community Paediatrician]		
CP60	All Community Paediatrician Services [excluding vaccination programmes]		

254 This is an initial step in attempting to understand the levels of activity undertaken by community physicians. It is anticipated that in future, the collection requirements in these areas shall become more refined.

Section 12 – Specialist Services (Note that Critical Care Services can be found in Section 3)

255 Work is ongoing to define the range and scope of specialist services and as these definitions emerge, they will be assessed and reference cost requirements adjusted if necessary to ensure consistency where possible. This section covers: -

- Renal Dialysis
- Renal Transplantation
- Bone Marrow Transplantation
- Spinal Injuries
- Cystic Fibrosis
- Rehabilitation Services
- Radiotherapy &
- Chemotherapy

Renal Dialysis

256 The development of a National Service Framework for Renal Services offered the opportunity to clarify the approach taken for this service. The requirements have not changed from those that formed the 2003 collection.

257 Dialysis sessions i.e. each session of dialysis treatment on a given day for each patient, continue to be used for reference costs purposes. To assist NHS providers in planning their work to provide this mandatory collection and return, the working definition of each session for each patient across the financial year can be used.

258 The approach is consistent with other high cost treatments, namely that dialysis should be excluded from HRGs and the costs shown separately.

259 As part of the development of the National Service Framework for Renal Services, and the developmental work on national tariffs, a number of changes in the reporting of dialysis have been agreed. The renal dialysis categories and the rationale are set out below.

260 In a refinement of previous years, and in response to NHS feedback concerning the level of resource utilisation for children receiving renal dialysis, data submitted for renal dialysis is required to be reported separately for adult [17 years and over] and child [up to and including 16 years old] patients in 2006. In this first year, the categories used will remain as:-

- Hospital based Haemodialysis
- Hospital based Haemodialysis for patients with Infectious Disease
- Hospital / Satellite based Holiday Haemodialysis
- Satellite based Haemodialysis
- Home based Haemodialysis
- Continuous Ambulatory Peritoneal Dialysis (CAPD)
- Automated Peritoneal Dialysis (APD) (including Intermittent Peritoneal Dialysis, Continuous Peritoneal Dialysis and Night-time Intermittent Peritoneal Dialysis).

261 A separate categorisation has been introduced for hospital (main unit) and satellite (hub and spoke) haemodialysis because of the expected difference in staffing intensity and cost, with “at risk” patients normally treated at the main unit.

262 In costing CAPD, the cost of the bags (i.e. per session) is a major cost driver. In costing APD, the cost of the fluids for exchange, plus the operating costs of the machine facilitating the exchange, should be included.

263 In a number of cases, drugs related to associated conditions are required e.g. anaemia. These drug costs should be treated as any other cost of treatment and attributed at the point of delivery or as in outpatients, the point of commitment. **In order to improve understanding of the cost data reported,**

the Reconciliation Statement Z introduced in 2004 was mandated in 2005, being auditable as at that date. For renal dialysis services, this Statement will continue to require organisations that have included/ incurred the costs of EPO as part of providing their renal dialysis service to identify them separately. Full details of Statement Z requirements for 2006 will be available in early February 2006.

Renal Transplantation

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

265 As in 2005, HRG L01 will not be used for Kidney transplants. Rather, the following categories will be collected in 2006: -

- Adult Kidney Transplant
- Child Kidney Transplant (up to 16 years).

266 **These categories are to be used only for kidney transplant activity and only for those patients that receive a kidney transplant**. The cost of kidney transplants should include the costs incurred of matching to suitable donors.
The cost and activity data relating to kidney **donors** should be reported using the relevant (non-transplant) HRG. This clarification has been introduced to address the issues of the loss of appropriate activity data when the reporting of donor and recipient activity and costs for kidney transplants is combined. Thus the donor will count as a single FCE and the recipient as a separate (kidney transplant FCE), in line with the data standards FCE definitions.

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

Bone Marrow Transplantation

268 In working on the definitions of specialist services, it has become clear that there are cost variations between the different types of transplantation and that these are masked within one grouping.

269 The 2004 collection introduced seven new categories for Bone Marrow Transplantation, each sub-divided between adult and child. The categories, which are retained in 2006, are as follows:

- Autografts – Bone Marrow
- Autografts – Peripheral Blood
- Allografts – Bone Marrow or Peripheral Blood – Sibling Donor
- Allografts – Bone Marrow or Peripheral Blood – Matched Unrelated Donor
- Allografts – Bone Marrow or Peripheral Blood – Mismatched Family Donor, Mismatched Unrelated Donor, Haplo-Identical Donor
- Autografts – Cord Blood
- Autografts – Other
- Severe Combined Immune Deficiency Syndrome

270 Post transplantation drugs, particularly anti-rejection drugs are a significant cost driver and these have a significant distorting effect on outpatient costs after a patient is discharged as an inpatient. In many cases these costs are treated as an overhead across a wider category of patients. To address the concerns of NHS commissioners and providers about the costs of these services, post transplantation outpatients are separately identified within the outpatient classification.

271 As for all transplantation services, the general principle for Reference Costs purposes is that the costs and activity relating to the **recipient** of a transplant are reported using the appropriate transplant HRG / service code category, whilst the cost and activity relating to a transplant **donor** are reported using the relevant (non-transplant) HRG as appropriate. This approach should ensure that all relevant activity is captured and reported.

Spinal Injuries

272 Specialist Spinal Injury Units have been reported separately since 2002, in line with specialist commissioning definitions for these services.

273 Only eight units have been identified under the specialist commissioning work and **only these units will be allowed to submit details within this category.** These units are:-

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

274 When these patients undergo surgery, the hierarchy has grouped episodes with long lengths of stay to the minor surgical procedures, e.g. fitting of catheter. This has led to distortion. For spinal injury patients within the above units, patients should be recorded and costed on an occupied bed day basis as length of stay is a more powerful cost driver in these circumstances than the majority of surgical procedures. Where surgery is undertaken, the costs of surgery should be costed and recovered through the occupied bed day cost, i.e. all costs associated with the surgery should be treated as an oncost on the inpatient stay.

275 Some teaching hospitals (outside the above specified list) still have concerns about the spinal work they undertake and the appropriateness of some of the existing HRGs to accurately reflect this activity. For 2005, these NHS Trusts should still use existing HRGs and outpatient classifications. These concerns will be reviewed as part of an overall review of HRGs. No organisation should exclude these services from their reference costs submission.

276 In line with developments in other specialised services, existing activity categories for spinal injuries are sub-divided between adults and children.

Cystic Fibrosis

277 Cystic Fibrosis services appeared as a separate category for the first time in reference costs in 2003. This was facilitated by the national specialised services definitions for Cystic Fibrosis. This section should be read in conjunction with Section 7 – Outpatients.

278 Cystic Fibrosis categories should be used where a patient is receiving treatment for their cystic fibrosis condition, not where a patient with cystic fibrosis is receiving medical treatment for other, unrelated conditions. Note that in HRG version 3.5, it is expected that this activity would fall within HRGs D17 and P02. However, please note that cost and activity data for such services are not reported using these

HRGs in Reference Costs, but rather, are re-classified into the relevant banded Cystic Fibrosis patient category.

279 Costs for the different categories of patients need to be split between adults (17+) and children (up to and including 16).

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

- Band 1
  Patients, who come only to outpatients, receive outpatient care in terms of input from physiotherapist, doctors, social workers, dieticians, etc.
- Band 2
  Patients who receive the above and in addition receive outpatient intravenous antibiotics 3-4 times a year. They may be occasionally admitted. The input as an outpatient may be more intense.
- Band 3
  Similar to 1 and 2 but essentially intravenous antibiotics are received as an inpatient 3-4 times a year. They may also have diabetes, require feeding gastrostomies, and clearly have a higher input.
- Band 4
  These patients have severe disease, come into hospital 3-4 times a year for intravenous antibiotics, and have increasing disease severity. They may have diabetes and more resistant organisms. They may be under consideration for transplantation.
- Band 5
  These patients have usually been in Band 4 for at least a year and need to stay in hospital for 4-6 months awaiting transplantation or palliative care. They are unable to go home because of oxygen dependence, nocturnal ventilation and feeding gastrostomies and need intravenous antibiotics every day, sometimes for 2-3 years. Patient's life expectancy is usually no more than a year to 18 months

.

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

282 Band 2, 3 and 4 patients may have inpatient episodes throughout the year and therefore these episodes need to be counted and costed as finished consultant episodes in each band.

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

Rehabilitation Services

284 Rehabilitation in this collection is used to describe:

- Patients who are admitted for rehabilitation;
- Patients who are treated on a discrete rehabilitation ward/unit;
- Patients who are treated under specialty code 314.

285 The costs and activity for these patients should be reported on a cost per occupied bed day basis. If discrete rehabilitation wards also include acute beds, where possible, the costs and activity relating to this acute, non-rehabilitation care, should not be reported as rehabilitation, but should be reported using the appropriate version 3.5 HRG and specialty. Where this is not feasible, it is acceptable to include all activity undertaken on rehabilitation wards as 'Rehabilitation'.

286 Increasingly, rehabilitation services are provided by community hospitals following transfer from an acute provider. Community hospitals should note the following when identifying and reporting such services for reference costs.

- For community hospitals that provide a rehabilitation service, this should be reported as rehabilitation on an occupied bed day basis, by patient category (see paragraph 287 below).
- When patients are admitted to a community hospital after discharge from an acute provider (i.e. a different organisation), the patient may be admitted under the (previous) acute HRG.
  Community hospitals that provide rehabilitation services should submit this data as Rehabilitation (i.e. because that is the service being provided), rather than using the acute HRG that relates to the condition for which the patient has undergone treatment in the acute provider.
- Where patients are transferred from acute to community hospitals whilst in an acute stage of treatment (to facilitate early discharge) and still require acute care and stabilisation before rehabilitation treatment, organisations should report the acute phase of care using an appropriate specialty and HRG, and report the rehabilitation using the appropriate 'Rehabilitation services' category.
  It is inappropriate to report the post-acute element of care as rehabilitation, and it may be similarly inappropriate to report it as the discharge HRG from the acute provider.

287 The types of patients that require rehabilitation vary considerably. Some patients such as those with spinal injuries are already separately identified elsewhere in the collection. Other categories still need to be separately identified however. The categories in the 2006 collection remain as : -

- Stroke
- Brain Injury
- Other Neurological Rehabilitation
- Elderly
- Other

The 'other' category may be sub-divided further in future years, based on feedback from the Service.

288 In addition, the first three categories are sub-divided between children and adults.

289 Rehabilitation **should not** be used to describe:-

- The cost of activity beyond an HRG trimpoint for any 'acute' or non-specified HRG. This should still be reported as excess bed days.
- Routine, post-operative rehabilitation. The costs of this should be reported in the composite costs of the relevant HRG.

Radiotherapy and Chemotherapy

290 Radiotherapy and chemotherapy treatment costs should be separated out of the composite costs of other treatments and shown separately. This is consistent with the approach clarified in 2004.

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

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

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

Radiotherapy

292 Radiotherapy HRGs are to be used for the **treatment** costs of radiotherapy services only, regardless of the location in which the treatment is given e.g. outpatient, inpatient etc. These groupings are unchanged from previous collections.

Non-treatment costs, including ward costs, etc. should be reported using the appropriate version 3.5 HRG and relevant locally determined specialty.

293 In 2006, the collection currency for Radiotherapy is the number of individual treatments (or fractions) in the financial year, **not the number of courses of treatment.** A single patient undergoing 6 fractions will thus be reported as **6** in the **relevant HRG category.** This change reflects the fact that collecting courses rather than individual patient treatment activity can distort cost variation in service delivery.

Chemotherapy

294 **The chemotherapy collection was extended in 2005 to include chemotherapy for both solid and non-solid tumours, and these are retained in 2006. In addition, for the purposes of reference costs, chemotherapy services only include chemotherapy that is solely for the treatments of cancer.**

295 Chemotherapy classification groups are to be used for the treatment costs (i.e. chemotherapy drugs (including any pharmacy dispensing oncost) and associated drugs to deal with the symptoms or side effects of the chemotherapy drugs themselves) of chemotherapy services only. Non-treatment costs, including ward costs, etc. should be reported using the appropriate version 3.5 (*98) HRG and relevant locally determined specialty.

296 In 2006, the collection currency for chemotherapy for both solid and non-solid tumours remains as **the number of individual patient treatment attendances for chemotherapy in the financial year, not the number of drug regimens.** A single patient attending for 8 chemotherapy treatments will thus be reported as **8** in the **relevant classification group category.** This change has resulted from concerns about the lack of consistency and comparability in drug 'regimen' data, and the need for a locally meaningful, clearly defined and nationally understood collection category for these services, as an interim measure until Version 4 HRGs are available for use.

Chemotherapy for Solid Tumours

297 **Chemotherapy classification groups have been amended to remove all reference to specific drugs, but retain site-specific classifications.** This is in acknowledgement of the fact that changes in clinical practice have resulted in certain chemotherapy HRG drug classifications being no longer current.

298 Although advances in clinical treatment mean that some chemotherapy continues to be administered intravenously, whereas other forms of chemotherapy are administered orally, due to the relatively small difference in cost anticipated between these forms of administration method, there is no requirement to separately identify them. Rather, both IV and orally administered chemotherapy should form part of the composite costs and activity reported in 2006. [Note that if local circumstances are such that differences in cost between oral and intravenous chemotherapy treatment are deemed to be significant, Statement Z should be used to separately identify the costs and activity of each of oral and IV chemotherapy administrations. Additional lines should therefore be added to reflect the detail within the composite costs and activity reported].

299 The classification groups for chemotherapy remain as follows:-

- X99BLC Bladder Cancer Chemotherapy - All Drugs
- X99BRC Breast Cancer Chemotherapy - All Drugs
- X99CEC Cervical Cancer Chemotherapy - All Drugs
- X99COC Colorectal Cancer Chemotherapy - All Drugs
- X99LNS Lung Non Small Cell Cancer Chemotherapy - All Drugs
- X99LSC Lung Small Cell Cancer Chemotherapy - All Drugs
- X99OEC Oesophageal Cancer Chemotherapy - All Drugs
- X99OVC Ovarian Cancer Chemotherapy - All Drugs
- X99SCC Stomach Cancer Chemotherapy - All Drugs
- X99TCC Testicular Cancer Chemotherapy - All Drugs
- X99OST Other Solid Tumour Cancer Chemotherapy - All Drugs.

300 Where a patient attends for a single treatment, and is prescribed a course of oral chemotherapy, the costs of the entire course should be reported as part of the composite costs of the treatment attendances that it relates to.

Chemotherapy for Non-Solid Tumours

301 Chemotherapy Services include chemotherapy for the treatment of non-solid tumours.

- As in 2004, Four broad classifications – '**leukaemia**', '**myeloma**', '**lymphoma**' and '**other**' are required for identification in the Reference Costs collection.
    - XY99LEU Leukaemia Non Solid Tumour Cancer Chemotherapy - All Drugs
    - XY99MYE Myeloma Non Solid Tumour Cancer Chemotherapy - All Drugs
    - XY99LYM Lymphoma Non Solid Tumour Cancer Chemotherapy - All Drugs (includes Hodgkins Disease Cancer Chemotherapy - All Drugs, and Non Hodgkins Lymphoma Cancer Chemotherapy - All Drugs)
    - XY99OTH Other Non Solid Tumour Cancer Chemotherapy - All Drugs
- These classifications are an interim measure for the short-term, prior to the introduction of version 4 HRGs. Work continues to define these classifications further.

302 Details of the Radiotherapy HRGs and the revised Chemotherapy classification groups are given in Appendix 6 of the NHS Costing Manual.

Home Delivery of Drugs and Blood Products

303 Some organisations incur costs in delivering drugs or blood products directly to patient's homes, without any associated outpatient / community activity. In order to ensure consistency in the calculation and reporting of cost and activity data in 2006, the costs of drugs that are delivered directly to a patient's home, continue to be excluded from the Reference Costs collection. This information will, however, continue to form part of the itemised services excluded statement (PSSC) in 2006, rather than being included in the collection proper.
Note that the costs of drugs administered as part of an inpatient episode, or outpatient attendance, must be reported as part of the composite costs of the particular service / treatment, etc.
Similarly, the main cost drivers for renal dialysis (bags and cost of fluids) are not classed as drugs, and therefore should be included in the total cost of the renal dialysis service.

Section 13 – Services Accessed Directly

304 Diagnostic support services such as Radiology and Pathology, that are undertaken as part of inpatient, day case, outpatient and Accident and Emergency care are included as part of the composite costs of these types of care, thereby maintaining the full absorption cost and matching principles that underpin the NHS approach to costing services.

305 There are however, numerous occasions when such diagnostic tests and services are carried out independently of these other types of care. These instances have, to date, been labelled as 'direct access, the associated costs of the majority of which were introduced as part of the collection in 2001. However, the term 'direct access', when used by the NHS, has tended to imply referral by a GP only, irrespective of the fact that both GP referred and non-GP referred (e.g. other healthcare professional, etc.) patients can attend the same setting for identical treatment. **This distinction between source of referral is no longer appropriate for Reference Costs purposes, and therefore this activity is now re-classified, as 'Services Accessed Directly', thereby relating to all sources of referral for diagnostic tests and services outside the inpatient, day case, outpatient, Accident and Emergency and Intensive Care settings.**

Radiology and Pathology

306 These services are widely provided in the NHS and continue to form part of the mandatory collection in 2006. It is anticipated that the interest in this area of service delivery will increase with the extension of PbR, in future years.

307 When producing costs on a full absorption costing basis, care should be taken to ensure that the entire costs of such services are included in calculations, namely:-

- That radiology costs include costs incurred in reporting, rather than just the costs of imaging;
- That pathology costs include costs incurred in the transportation of samples.

Pathology Services

308 The category of phlebotomy within pathology services directly accessed by a patient was introduced largely as a result of requests from PCTs, who provide a blood collecting service, but have no access to laboratories in order to carry out pathology tests. This category should therefore be used for discrete phlebotomy services only. Non-discrete phlebotomy services should continue to be included as part of the composite cost of the relevant pathology specialty, as in previous years.

309 A robust definition of a pathology 'test' has remained elusive in reference costs to date. In 2006, the following definitions, developed by the National Pathology Alliance Benchmarking Review, should be used, wherever possible: [Note that the data standards definition of a request for pathology investigation can be found at
`http://www.nhsia.nhs.uk/datastandards/pages/ddm/data_dictionary/classes/r/rep/request_for_pathology_investigation_de.asp?shownav=1`

- Clinical Biochemistry

  Requests: Work received from a single patient at one time usually, but not always, on a single specimen. A GP multi-request form for three departments e.g. Microbiology, Haematology and biochemistry, with a blood sample for investigations in all three departments, would be one request in each of the three departments.

  Tests: A result produced by an analytical process on a single specimen. Calculated results and comments describing a test or result should NOT be counted as tests.

- Haematology

  Requests: A request should be patient focused and related to specimens taken from one patient at one time whether they are dispatched to the department in one or a multiplicity of

containers. A GP multi-request form for three departments e.g. Microbiology, Haematology and Biochemistry, with a blood sample for investigations in all three departments, would be one request in each of the three departments. (Samples taken from one patient at the same time may arrive in the laboratory at different times – they are still one request).

Haematology Tests: A test is the output of either, one analysis or a number of related analyses on a single analyser.

- Microbiology

  Requests: A request is one sample (which would normally receive one laboratory number.)

  Tests: Work carried out as a single protocol of related work on one sample where reporting of only part of the work would be regarded as an incomplete result. However, to account for the additional work associated with clinically significant culture positive specimens (identification and/or antibiotic sensitivity procedures); these further procedures should score as one additional test per organism.

- Cellular Pathology

  Requests: A request should be patient focused and relate to specimen(s) taken from one patient at one time whether dispatched to the department in one or a multiplicity of containers and related to a single request form.

- Immunology

  Requests: Receipt of a single laboratory request form and accompanying appropriate specimen(s) drawn from an individual patient at one time, the whole of which having been submitted at the same time by a referring clinician.

  Test: A single analytical procedure.

310 The requirements for 2006 therefore comprise cost and activity calculated and reported on a test basis for:

- DAP823 Haematology
- DAP824 Histology / Histopathology
- DAP830 Immunology
- DAP831 Microbiology / Virology
- DAP832 Neuropathology
- DAP838 Cytology (should not include cervical screening programmes)
- DAP839 Phlebotomy
- DAP841 Biochemistry
- DAP842 Other

311 As in previous years the 2006 collection requires cost and activity data to be submitted on a test basis, with the number of requests continuing to be required as a memorandum activity item on the collection files. Note that a unit cost per request is not required.

Radiology Services

312 Radiology bandings used in the Reference Costs collection relate to the Korner bandings A to L. Full details can be found in the NHS Costing Manual (Appendix 7).

313 The categories for Radiology services directly accessed by a patient therefore comprise the following:

- RBA1 Band A
- RBB1 Band B1 - Mammography

- RBB2 Band B2 - Maternity Ultrasound
- RBB3 Band B3 - Other Ultrasound
- RBB4 Band B4 - Other Band B Tests
- RBC1 Band C1 - Mammary Ductography / Mammography
- RBC2 Band C2 - Ultrasound
- RBC3 Band C3 - CT Pulmonary Angiography
- RBC4 Band C4 - CT Radiotherapy Planning
- RBC5 Band C5 - CT Other
- RBC6 Band C6 - Other Band C Tests
- RBD1 Band D1 - CT
- RBD2 Band D2 - Maternity Ultrasound
- RBD3 Band D3 - Doppler Ultrasound
- RBD4 Band D4 - Other Band D Tests
- RBE1 Band E
- RBF1 Band F1 - MRI
- RBF2 Band F2 - Other Band F Tests
- RBG1 Band G - Radionuclide (Isotope) Tests
- RBH1 Band H - Radionuclide (Isotope) Tests
- RBJ1 Band J - Radionuclide (Isotope) Tests
- RBK1 Band K - Radionuclide (Isotope) Tests
- RBL1 Band L - Radionuclide (Isotope) Tests
- RBX1 Band M – PET Scan
- RBX2 Band X – DEXA Scan

314 The introduction of PET Scans and DEXA Scans in 2006 is in response to the greater number of NHS providers that are now offering this facility outside of the inpatient, day case, outpatient, accident and emergency and intensive care setting, and the impact that other Department of Health policies, such as CHOICE, may have on such service provision. **Note that the costs of such scans that are incurred as part of an inpatient or day case episode, or an outpatient or accident and emergency attendance, or a critical care occupied bed day, must continue to be reported as part of the composite cost of that inpatient / day case / outpatient / accident and emergency treatment.**

Other Services

315 An ever-increasing range of services, including physiological tests, can be accessed directly by a patient, outside of inpatient, day case, outpatient and Accident and Emergency care settings.

316 In a change to 2006, and in response to NHS feedback, the categories for clinical measurement tests have been revised, and extended considerably, to better reflect the type of tests now undertaken in this setting.

317 The list of clinical measurement tests that are to be reported in 2005 will therefore be as follows: -

- 24 hour ECG / BP Monitoring
- Carpal Tunnel Screening
- Diabetic Retinal Screening
- Fluroscein Eye Screening
- ECG (12 lead)
- Echocardiogram
- Electrocardiogram
- Electromyography (EMG) / Electroencephalograph (EEG)
- Exercise Test (including Treadmill, etc.) / Stress Test
- Hydrogen and Urea Breath Tests
- Long-term Oxygen Therapy Test
- Nebuliser Assessment Test
- Spirometry Test and Broncho Dilator Response Test
- Other Test.

318 Angiography and Diagnostic Endoscopy: Note that these should be reported under the appropriate procedure category. A separate category is no longer required.

319 Note that the category for Dietetics direct access is no longer required in 2006. It has been superceded by the introduction of Dietetics into the outpatient collection.

Section 14 – Other Community-based Services

320 The NHS provides a range of other community-based services that have not been covered by this guidance to this point. A number of services currently remain excluded from reference costs. These are listed in Section 17.

321 A number of services are included, however, which do not fit into other sections, and these are: -

- Chiropody
- Podiatry
- Dietetics
- Diabetes
- Community Dentistry
- Hospital at Home / Early Discharge Schemes
- Community Rehabilitation Teams

Chiropody and Podiatry Services

322 These services can be delivered in a number of settings, such as the patient's home, GP surgery, etc. All activity and costs for each service provided in a community setting need to be recorded, regardless of setting, using attendances as the base activity measure. Where this type of activity is provided as part of an admitted patient care or outpatient attendance, the costs should be reported within the composite cost of the admitted patient care HRG / outpatient attendance. Where the outpatient attendance is solely for podiatry services, in a hospital-cased clinic setting, costs and activity should be reported using specialty code 997 within the outpatient return [Section 7 refers].

323 Some patients directly access these services (as with a range of other services). As in 2005, **there is a requirement to separately identify cost and activity data for chiropody and podiatry services.**

324 For the purposes of Reference Costs,

- Podiatry is defined as the "assessment, diagnosis and treatment of conditions of the foot, with the aim of eradicating or controlling foot pathologies, where possible, with a scope of practice which includes general podiatry, biomechanics, surgery, high risk care and foot health education techniques".
- Chiropody is defined as "the maintenance of the foot in a healthy condition by recognised means in which the practitioner has been trained".
- Where clinicians do not differentiate between Podiatry and Chiropody Services at an organisational level, all such costs and activity should be reported as Chiropody.

Dietetics, Diabetes and Community Dentistry

325 As with physiotherapy, occupational therapy, and speech & language therapy, if these services are included as part of an inpatient or day case stay, the costs should be reported within the appropriate inpatient or day case HRG unit costs. Similarly, where the treatment is included as part of an outpatient attendance, the costs will form part of the composite costs of that outpatient attendance.

326 Other attendances (i.e. through direct access or from community based services) are shown separately. These are reported as attendances and are costed on a per attendance basis. This list remains consistent with those services collected as part of the 2004 collection.

327 Community dental activity should include both the costs and activity of face to face dental officer activity in clinics, and also the costs and activity of 'screening' contacts that such officers carry out in schools (where each child screened constitutes an attendance, since each requires one-to-one activity).

Hospital at Home / Early Release Schemes

328 These schemes allow the early discharge of patients from hospital in order for them to continue their healthcare in other settings, i.e. primarily in their homes, and were introduced into Reference Costs for the first time in 2003. The requirement to report this data remains for the 2006 collection.

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

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

331 Services delivered are provided on a team basis and therefore for activity and costing purposes, it is the number of team contacts in a financial year that form the activity baseline. For example, if one patient is seen by a nurse for five days, twice by a physiotherapist, and once by an occupational therapist, this is **8** team contacts in the financial year.
Note that this example assumes that team members do not see patients on anything other than a team basis, i.e. that total clinical caseload for that professional relates solely to team activity.
Where this is not the case, and members of a clinical team also see patients in another capacity, e.g. as a Community Occupational Therapist, this activity, and associated costs, should not be reported as part of the hospital at home / early release scheme team activity, but rather, should be reported using the relevant classification within the appropriate community-based collection, e.g. community-based occupational therapy, etc.

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

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

334 These schemes are different from Intermediate Care and Step Down Beds. Within Hospital at Home / Early Release Schemes, there is a projected end date for the care plan, following a patient's early release from an acute admission. Intermediate Care and Step Down Beds usually have a longer care path and can be delivered in hospital and community beds; these services remain excluded in 2005.

335 **Note that this service can be found on the Specialist Services collection file** in 2006 (not Community Services).

Community Rehabilitation Teams

336 Community Rehabilitation Teams are usually comprised of a number of health care professionals, and provide ongoing care to patients in a community setting. The range of services provided by these teams will vary on a patient by patient basis, although the care usually includes nursing and a range of therapy services.

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

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

Note that this example assumes that team members do not see patients on anything other than a team basis, i.e. that total clinical caseload for that professional relates solely to team activity.
Where this is not the case, and members of a clinical team also see patients in another capacity, e.g. as a Speech and Language Therapist, this activity, and associated costs, should not be reported as part of the community rehabilitation team activity, but rather, should be reported using the relevant classification within the appropriate community-based collection, e.g. community-based speech and language therapy, etc.

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

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

341 Some community rehabilitation teams provide rehabilitation services for patients with specific diagnoses or conditions, for example, neurological community rehabilitation teams. At present, there is no requirement to separately identify the types of rehabilitation services that these teams provide. Cost and activity data for services provided by all community rehabilitation teams should be reported using the single composite category in 2006.

342 **Note that this service can be found on the Specialist Services collection file** in 2005 (not Community Services).

Section 15 – Commissioned / Sub-contracted work from Non-NHS and Voluntary Health Sectors

343 Under the Concordat arrangements, a higher focus has been given to the use of the private sector in delivering care to NHS patients. This is only one aspect of the relationship with the NHS however.

344 Commissioners have set contracts for delivery of care with the private and voluntary sectors for several years. These have ranged from local agreements with an independent GP to extend a service across patients for a group of services (beyond GMS requirements) to an agreement for set volumes of activity each year with a local private hospital. In addition, patients based in voluntary sector establishments such as hospices, SCOPE, MIND, etc., are also widespread, although work subcontracted or commissioned from the voluntary sectors is still excluded from this collection.

345 NHS providers have also sub-contracted work to the private/charitable sector in a number of circumstances such as meeting waiting list targets, and emergency mental health admissions.

346 In 2003, NHS providers who sub-contracted work from outside of the NHS (i.e. both private/charitable sector organisations), were required to separately identify this activity and cost at a more detailed level. For all services/providers, the level of detail is the same as for the provision of their own services. This assisted in identifying the suspected cost differentials between different sectors, and avoided cross-subsidisation of costs between different types of providers.

347 The requirement to separately identify resource use by NHS organisations for NHS patients outside the NHS continues in 2006. As in 2005, NHS organisations will be required to provided a single set of composite collection files, that combine unit cost and activity data for non-NHS providers from whom they acquire health services.

348 There is no requirement to separately identify work sub-contracted to other NHS providers.

349 If work undertaken by the private/charitable sector was only reported by NHS providers, the overall levels of activity and cost for NHS patients would be understated.

350 The 2006 collection requires that **ALL** commissioners of services for NHS patients will be required to submit data as part of the reference costs collection, **for services directly commissioned from and delivered by non-NHS providers, including Independent Sector Treatment Centres. No data is required for contractual agreements with NHS providers.**

351 **NHS Trusts may therefore need to make two sets of returns for reference costs, depending on whether they receive health care activity from non-NHS providers:-**

- A standard reference costs return for the full range of their **Owndata provider** function; &
- A **ContractedOut** reference cost return for all services that are sub-contracted to non-NHS providers.

352 **PCTs may be required to submit three sets of returns for the different strands of their work: -**

- A standard reference costs return for the full range of their **Owndata provider** function;
- A **ContractedOut** reference cost return for all services that are sub-contracted to non-NHS providers;
- A **Commissioner** reference costs return for all services that are directly commissioned from and delivered by non-NHS providers.

353 As a general guide, PCTs and NHS Trusts tend to sub-contract activity to non-NHS providers where they are unable to meet capacity requirements / external targets such as waiting list initiatives, etc. Only PCTs can legally commission services, and generally, they do not provide the services that they commission directly from non-NHS sources.

354 At this stage, all activity commissioned from and delivered by some areas of the Charitable and Voluntary sector continues to be outside the scope of reference costs. This exclusion covers the work of hospices and charitable organisations as specified in the excluded list in Section 17 of this document.

Section 16 – Non-contractual Income

355 One of the most significant items that impacts on the overall reference costs quantum is the level of non-contractual income that an NHS provider receives.

356 In comparing and benchmarking costs, this income can have a distorting effect on the range of costs for given treatments and procedures. Under the NHS Costing Manual, these forms of income have to be matched to the services to which they relate. Therefore, if Trust A receives £1m Research and Development funding and Trust B receives none, all other things being equal, the quantum for Trust A is reduced. Consequently, this will impact on the reference costs unit cost data.

357 In trying to explain cost variations between providers for the same treatment, therefore, the level of these alternative income streams can have a significant impact.

358 As in 2005, the reference costs collection continues to include information on the overall levels of funding from non-contractual income. This data forms part of the reconciliation statements in 2006 (Provider Services Statement - PSSY).

359 The collection requires the actual sums received (in £) for 2005 / 2006 financial year from the following areas : -

- National Child Care Strategy
- Improving Working Lives Initiative
- NVQs and NHS Learning Account
- Continuing Professional Development
- Service Increment for Teaching
- Medical and Dental Education and Training Allocations (previously MADEL)
- Nursing and Midwifery Education (previously NMET)
- Other Income Received
- Other Charitable Contributions

360 Note that income relating to Trust Funds is not required in 2006.

361 Summary points to note with regard to the treatment of income are as follows :-

- The treatment for each of these income sources should be the same as in previous years; the income should be matched to the relevant expenditure and netted off from the reference costs quantum of costs.
- The income should not be excluded from the reference costs, as to do so, would increase the total expenditure submitted as part of the reference costs returns by in excess of £1 billion in the collection and affect data comparability.

362 Primary Care Trusts with teaching status or having other non-contractual income should also complete this part of the return. No differentiation is made between PCTs and any other NHS Provider having teaching status. The standard NHS Costing Principles on the treatment of these income streams should be applied consistently.

363 Concerns have been raised by the NHS regarding the types of income that should legitimately be classified as Category C, and thus netted off from the reference costs quantum. Appendix 4 of this document provides details of those items that are allowable as Category C (i.e. can be netted off the Reference Costs Quantum of Costs) in 2006. This should ensure that there is greater consistency in Category C income classification, and thus impact, in future reference costs collections.

Section 17 – Services Excluded from Reference Costs

364 The focus of the 2006 collection remains one of consolidating current collection requirements, and improving data quality where possible. As a result, there is limited extension to the services covered.

365 Although updated in 2005, the lists below are by no means exhaustive, and should be read in conjunction with Appendices 2 – 5 inclusive of this document. Where queries concerning a particular aspect of service inclusion or exclusion arise, please contact the Costing section of the PbR team at the Department of Health, for clarification. Please do not exclude services that are not listed, on the basis of historical reporting convention, without checking.

366 For information, the provider statement of services excluded (PSSC) that forms part of the mandatory reconciliation statements will itemise specific service areas that are excluded from Reference Costs 2006. Note that this form requires identification of the activity measure being reported. This information is then used to try to determine whether there are any activity measures currently in use in the NHS that could be adapted as appropriate currencies for future collections. There will be the facility to add additional lines, as in previous years.

367 The total costs of services excluded should be calculated using total absorption costing, and should therefore reflect the entire cost of the service excluded from reference costs, rather than just the direct costs of that excluded service.

368 **Services Excluded**

- Complementary Treatments (e.g. Aromatherapy, Homeopathy where discrete services)
- Counselling Services, where discrete (if not a discrete service, the costs will be included as an on-cost to the service area it relates to, e.g. termination counselling in gynaecology outpatients).
- Drop In Centres
- Extra Corporeal membrane Oxygenation [ECMO]
- Foetal Medicine (as a discrete specialist service)
- Forensic Psychiatry (except in secure units)
- Genetics (including molecular genetics)
- GMS services (all)
- Health promotion and prevention (where separate services)
- HM Prison related health services
- Hyperbaric chamber services – including oxygen therapy and detox.
- IVF and other fertility treatments
- Learning Disability Services (it is expected)
- NHS Direct (irrespective of NHS provider)
- Patient Transport Services (NHS Ambulance providers **only** to exclude from their submission) Photopheresis [highly specialist service - two providers only]
- Pregnancy Advisory Service (discrete counselling)
- Psychology service, where discrete (including neuro-psychology. Note that where neuro-psychologists are providing treatment as part of 'routine' care, they should be treated as an oncost to the neurology service)
- Psychotherapy (discrete service)
- Services for the Physically Disabled (e.g. Young disabled centres)
- Screening services that are part of a **national** screening programme (other than audiological neo-natal screening); note that screening services that are part of 'routine' treatment are not excluded, but should form part of the composite costs of that treatment.

369 **Elements of Service Excluded**

- 24 hour Intensive Nursing in the community
- Admission Prevention Schemes (Community-based)
- Air Ambulance services (NHS Ambulance providers only to exclude from their submission)
- Artificial Eye Fitting (The specialist [discrete] artificial eye fitting service provided by an Ocularist [including making, fitting & aftercare checks on the artificial eyes) are excluded, but any preparatory surgery, etc will be included within the admitted patient care costs and activity).

- CBRN costs for NHA Ambulance Service providers [Note that only pure CBRN costs and activity can rightly be excluded from Reference Costs. The elements of cost / activity that relate to non-pure CBRN items should be included in Reference Costs].
- Cochlear & Bone Anchored Hearing Aid Outpatient Maintenance
- Community Cystic Fibrosis
- Decontamination Services/units provided by NHS Ambulance Service Providers only
- Digital Hearing Aids service (in entirety; not just aids themselves)
- Domiciliary Visits that attract a fee for the additional service (apart from Mental Health domiciliary visits that are included and separately identified). Normal domiciliary visits undertaken by community / other nurses / therapists for which they are not paid an additional fee are included in Reference Costs 2005
- Home Delivery of Drugs where no associated activity is available
- Intermediate / Continuing Care (including Mental Health Services)
- Intensive Care Follow Up Clinics (part of national trial)
- Intensive Care Packages in the Community (usually named patient basis)
- Methadone Swallow and Depot Injection Clinics
- MH Counselling and Therapy (except those services provided through day centres/hospitals)
- Multi-Professional Triage Teams
- Needle Exchange Schemes
- One Stop Shops / Rapid Diagnostic Packages (including advice centres)
- Parentcraft Classes/services
- Plasma Exchange Scheme
- Specialist Services for the Deaf
- Spinal Care Packages in the Community
- Step Down beds in residential facilities
- Vaccination programmes that are part-funded by non-NHS providers (including GPs).
- Well babies – activity excluded, costs reported as part of the total costs of the maternity delivery episode.

370 **Support Services Excluded**

- Community Residential Care Homes
- Discrete External Aids & Appliances Services (including artificial limb/eye services, shoes and wigs.
- Home Equipment Loans
- Medical Loans
- Nursing Homes
- Resettlement Programmes (adult & elderly)
- Section 28a Homes
- School exclusion services
- Welfare Foods
- Wheelchair services.

371 **Other Exclusions**

- All Charities for People with Learning Disabilities, e.g. SCOPE
- All Charities for Physically Handicapped Services
- Clinical trials (unless the costs incurred are an accurate indication of what the actual costs of that treatment would be, outside the clinical trial setting. If the impact of income for clinical trials is such that to nett it off would produce unrealistically low, zero or negative costs (i.e. surplus income), the costs and activity relating to such trials must be excluded)
- Emergency Dental Services
- GP open access, e.g. where patients access open access services provided by GPs, NOT open access services whereby GPs refer patients to Trusts.
- GP Out of Hours service
- Hospice Movement
- MIND
- NHS LIFT set up costs only
- Personal Dental Services (PDS) pilots
- PFI set up costs only – see Appendix 5 for further details

- Pooled / Unified Budgets (see Appendix 6 for further clarification)
- Private Patients (also includes military patients, where funding for treatment of these patients is received from the MoD. Note that the income received from the MoD should be netted off, rather than the costs incurred in treating these patients being excluded. Note also that to exclude the costs and nett off the income received for such patients is not allowable; to do so would understate the quantum of costs by effectively 'double-netting off').
- Social Services (unless specifically stated above).
- Voluntary first responders utilised by Ambulance NHS providers

Appendix 1

Reference Costs – A Beginner's Guide

We hope this will provide some helpful tips and a logical approach for anyone who is new to Reference Costs!

Key Questions

What is the Deadline for Submission?

The deadline for submission is **Friday 30th June 2006**. A letter detailing where and how to access the 2006 Reference Costs Collection / Submission website will be sent out to SHA Reference Costs leads in April / May 2006.

What Guidance is Available?

There are two essential documents that you will need.

I. The NHS costing manual (updated in May 2005) which sets out the principle for costing in the NHS.
II. This document – the reference cost collection 2006, which provides specific guidance on reference costs for the 2006 collection.

They can be downloaded from the reference cost website:
http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSCostingManual/fs/en

Key Contacts?

Each SHA has a designated Reference Cost lead. These are listed in Annex 1 of this document. All queries regarding reference costs should be addressed to your SHA lead in the first instance.

Local costing groups have been set up across the country. These are a good way of meeting other reference cost leads and sharing issues / problems. Your SHA lead will be able to provide details of such groups.

Another way to find out information and to ask questions is on the discussion forum website. This is an informal website, which is now heavily used to ask questions of DH and to ask the advice of other costing colleagues. The (universal) login / password is 'refcosts03' & 'smile'.
Whilst the site is intended to share knowledge between NHS personnel, responses are monitored and DH will intervene where responses appear to be contrary to current guidance. We endeavour to answer all questions addressed directly to DH.

http://194.200.241.107/fd/refcostsdisc.nsf/main?readform

Starting Points for Reference Costs

Activity

This reference cost guidance sets out the activity requirements for 2006. As a starting point we recommend that you work through the guidance to determine which services your organisation provides and how that activity needs to be counted for reference cost purposes. You will then need to find out whether that activity information is already collected.

If data is not available, a sample or clinical estimate is acceptable for some services (as indicated in relevant sections in the 2006 guidance) although actions should be put in place to collect the data for the following year. Information should be kept for audit purposes if a clinical estimate is made.
As a general rule you should include all activity data that your organisation undertakes unless the reference cost guidance explicitly states that it should be excluded. We suggest that you liase closely with your information department to ensure that all activity data is captured and that the activity submitted is an accurate reflection of the activity data reported by your organisation in other activity returns such as HES, Korner, LDP

and signed SLA. Please note that the data in these returns may not exactly match your reference costs data and it may be necessary to provide a reconciliation between the various sets of data for audit purposes.

For inpatients, a download from your patient administration system will be required. This data then needs to be run through the software detailed below to group OPCS and ICD10 codes to HRG codes. There are several pieces of software which are needed to perform this task; the Grouper, Report Generator and the Episode to Spell Converter – these are available for download from the NHSIA* website below.

It is also important to note that before the activity download is fed through the grouper certain adjustments are required. These include excluding FCEs relating to well babies and excluding FCEs and bed days for activity where the costs and activity are reported separately for reference costs, such as critical care and rehabilitation.

http://www.icservices.nhs.uk/casemix/pages/tools.asp – Grouper V 3.5, Report Generator V 3.5, Episode to Spell Converter 3.1. This software is updated regularly therefore you should check that you are using the latest version.

http://www.nhsia.nhs.uk/phsmi/pages/trimpoints.asp – trimpoints are required for use with the Grouper (all activity over the trim point should be costed as excess bed days).

Costing

The principles for costing in the NHS are set out in chapter 2 of the NHS Costing Manual. The fundamental principle is that reference costs should be produced using full absorption costing. This means that each reported unit cost will include the direct, indirect and overhead costs associated with providing that treatment / care.

The costing guidance states that as far as possible costs should be directly allocated to specialty level. Where this is not possible, appropriate apportionment methodology should be used. The costing manual provides guidance on appropriate apportionment methodology and the treatment of indirect and overhead costs.
Given maintained audit involvement for 2006, it is vital that decisions and processes undertaken in apportioning costs are defensible.

We would suggest that the starting point for costing should be the month 13 ledger download. The TAC / ASF reconciliation illustrations (see Appendices 2 and 3 of this Guidance) provide details on how to calculate the correct quantum of costs for inclusion in your reference cost submission. You will need to provide details of your reconciliation from the reference costs to the final accounts for audit purposes.

For reference cost purposes category C income is included and therefore netted off against the costs of providing those services to which it is attributable. Information on what constitutes category C income can be found in Appendix 4 of this Guidance. Other categories of income must not be adjusted for in Reference Costs.

Validation of Reference Costs

We recommend that clinicians, general managers and information departments in particular, be fully engaged in the reference cost process.

We also recommend that any decisions taken should be documented for audit purposes, particularly if they involve a departure from existing guidance.

Plan work to allow sufficient time to validate your costs prior to submission to DH. The reference costs have increased in importance, as a result of the fact that they will form the basis for the national tariff each year. In 2006, as in previous years, a data quality report will be available (via web download) for all organisations, shortly after submission. In addition, a verification report, showing all data as submitted and including real time national averages will also be available via web download, within approximately three working days of submission. **It is important therefore that data submitted on the 30th June is as accurate as possible for these real time national averages to be meaningful.**

If Trusts find material differences in their reference costs they will be allowed to resubmit. The final date for re-submissions is yet to be decided, but will be approximately mid July 2006.

Excluded Services

The main premise in determining whether services other than those identified in relevant guidance or in Provider Services Statement C (PSSC) are excluded remains, i.e. whether you:

- Provide different services; or
- Provide services differently.

In the first instance, it may be acceptable to exclude such services as being outside the current scope of Reference Costs. Please e-mail such service-specific enquiries to the refcosts@doh.gsi.gov.uk mailbox for clarification and guidance.
Where services are provided differently, there is generally no scope for excluding these from the Reference Costs submission.

Clarification Regarding the 'Type' of Data Submission

There are three choices of type of data submission in the 2006 collection: 'Owndata', ' ContractedOut' & 'Commissioned'.

- For NHS Trusts and PMS+ pilot sites, their data submissions will either be ' Owndata ' or ' ContractedOut' (i.e. for services that are contracted out to non-NHS providers, **including Independent Sector Treatment Centres (ISTCs)**).
- For Primary Care Trusts, their data submissions may be ' Owndata ' or 'ContractedOut' (for PCTs acting in their capacity as providers of health care services) or 'Commissioned' (where the PCT directly commissions health care services from outside the NHS, including ISTCs).
  Only PCTs can commission services, therefore NHS Trusts / PMS+ pilot sites should not be submitting 'commissioned' data returns.

Commissioned and Contracted Data Requirements

⇨ NHS organisations will be required to produce unit cost and activity data for services that they sub-contract to, or directly commission from, non-NHS providers. They will be required to produce a single composite set of files for all non-NHS providers that they sub-contract with, and, **for PCTs only**, a single composite set of files for those non-NHS providers that they directly commission from.

⇨ As a general rule, PCTs will;
  - Sub-contract activity (from their Provider arm) to another provider (either NHS or non-NHS) where they themselves provide the service but have a problem with capacity.
  - Commission activity (from their Commissioning arm) directly from another provider (either NHS or non-NHS) where they themselves do not provide the service.

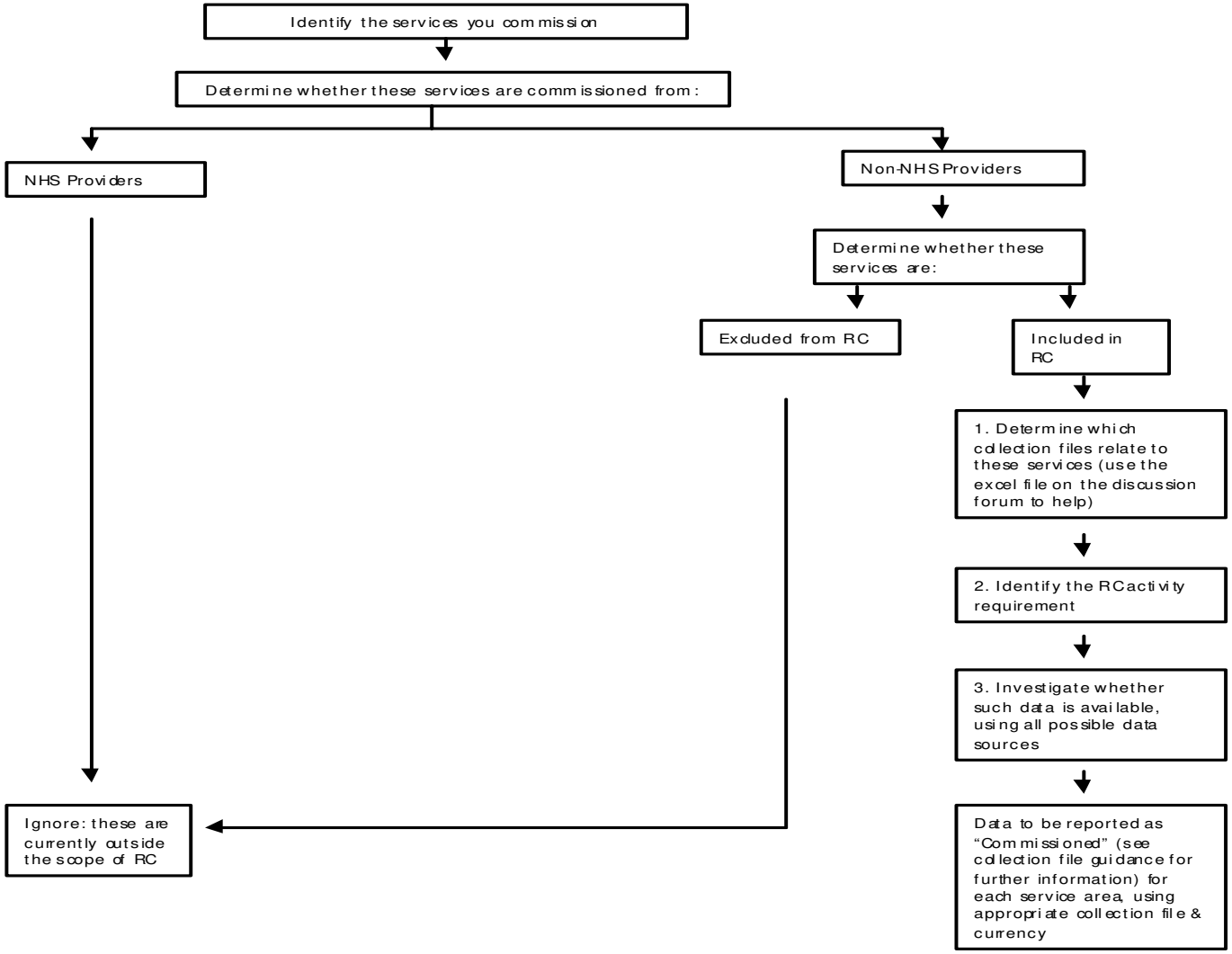
⇨ In reality, whether PCTs sub-contract services or commission them, tends to be the result of historic practices.

How Does the Process Fit Together?

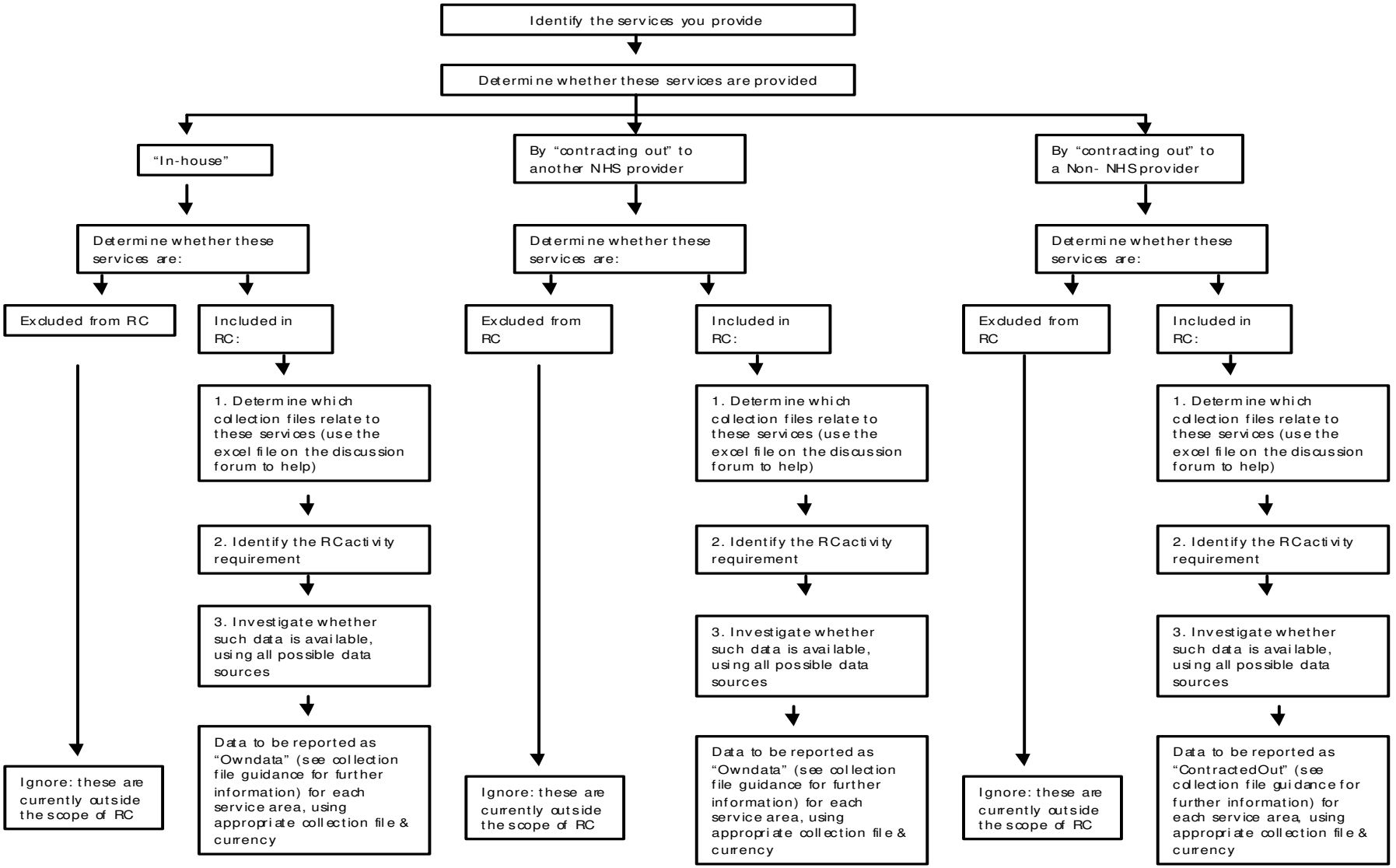
Flow diagrams can be found on the following pages, which attempt to illustrate the investigative process that NHS providers should undertake when determining what and how to submit Reference Costs information.

More detailed technical guidance will be issued with the collection files for 2006, which is expected to be released in April 2006.

For Primary Care Trusts Only



For NHS Trusts, Primary Care Trusts & PMS+ Pilot Sites



Additional Information for PCTs

Where PCTs are Host Providers and Commissioners

- ⇨ Where PCTs are host providers of a service for a group of PCTs, who sub-contract the service from the host PCT through their provider arm, the host PCT should not net off the income they receive under provider-provider agreements from each of the other PCTs, but report **all the costs and activity of providing this service** in their own return.
  The rule of thumb is that hosted services are all declared by the host PCT, unless they feed into other in-patient or out-patient activity, for other PCTs, in which case relevant costs are included within the unit costs and activity for that (other) PCT.
- ⇨ Where PCTs are the only providers of a service that is commissioned by a number of PCTs, they **continue to report all the costs & activity of providing this service in their own return** (there is no requirement for PCTs to report costs & activity that they commission from other NHS organisations).
- ⇨ Where PCTs are host commissioners of a service from non-NHS providers, they report the costs & activity of directly commissioning the service from non-NHS providers in a single (host commissioner's) 'Commissioned' return. Costs and activity should not be disaggregated between the PCTs that the host commissioner has commissioned the non-NHS activity on behalf of.

GPs with Special Interests

- ⇨ For GPs employed by the PCT, include the costs of and the activity that they provide in PCT 'Owndata' provider submission for outpatients.
- ⇨ For the GPs that charge you, either;
  a. They're acting in their capacity as part of the NHS therefore include the costs and activity in PCT 'Owndata' provider submission file for outpatients (no requirement to separately identify provider-provider agreements for other NHS providers);
  b. They're acting in their capacity as non-NHS providers therefore include the costs and activity in PCT 'ContractedOut' provider submission file for outpatients (requirement to separately identify and report services where these are sub-contracted to non-NHS providers).
- ⇨ Where these services are commissioned from the GPs, either;
  a. They're acting in their capacity as part of the NHS therefore ignore the costs and activity and report nothing (no requirement to report services commissioned from the NHS).
  b. They're acting in their capacity as non-NHS providers therefore report the costs and activity in PCT 'commissioned' commissioner submission file for outpatients (requirement to separately identify and report services where you commission these directly from non-NHS providers).

GSUP Activity

- ⇨ GSUP activity which is recorded locally but paid for centrally by DH should be excluded by PCTs as there is no cost to match with the activity.

Expenditure Reconciliation Statement 1 (PSS1)

- ⇨ Statement 1 is an NHS **Provider** Analysis of Expenditure Statement.
  The total cost column should therefore reflect the total provider costs that are incurred by an NHS organisation. This should be split between those costs relating to services currently included in the Reference Costs collection, and those services currently excluded from the Reference Costs collection. PCTs should not include costs relating to their commissioning role on this statement.

Appendix 2 – NHS Trust Reconciliation to TAC/FTC figures UPDATED FOR 2005!

NHS TRUSTS

Table 1: Reconciliation of TAC data to Reference Costs for NHS Trusts.

Line Count		Line Reference	£	
1	Operating expenses [TAC01]	120	705,781	
2	Less: Non NHS: Private Patients [TAC05]	160	- 15,000	
3	Less: Non NHS: Overseas Patients [Non Reciprocal] [TAC05]	165	- 3,450	
4	Less: Non NHS: Other [TAC05]	180	- 13,000	
5	Less: Other operating income [TAC01] [Please see Category C 'allowables' file]	110	- 239,855	
6	Less: Actual Cost of Distinction Awards [please identify separately]*		- 25,000	
7	Add: RTA income [Please Read Note] ***		52,000	
8	Less: RTA bad debts written off		2,100	
9	Add: items not allowable as Category C for RC [Please see Category C 'allowables' file]****		2,500	
10	Less: Actual Cost of Impairments **		- 65,000	
11	Add: Transfers from reserves in respect of impairments **		12,000	
12	Less: Actual Additional costs incurred as result of AfC Early Implementation **		- 65,000	
13	Less: Actual Funds received for Foundation Trust Application **		- 42,000	
14	Less: PFI Exclusions [Please see PFI Guidance file] **		- 30,000	
15	**Total Net Operating Expenditure:**		**276,076**	**REPORT LINE**
16	Adjustment for Provider-Provider Agreements [All Providers]		**- 35,000**	**REPORT LINE**
17	**Sub-Total**		**241,076**	
18	Add: Cost of fundamental reorganisation / restructuring [TAC01]	160	-	
19	Add: (Profit) / loss on disposal of fixed assets [TAC01]	170	223	
20	Less: Interest receivable	190	- 125,444	
21	Add: Interest payable	200	65,320	
22	Add: PDC Dividends payable	230	325,544	
23	Add: Other finance costs - unwinding of discount	210	67,400	**REPORT LINE**
24	Add: Other finance costs - change in discount rate on provisions	215	36,076	**REPORT LINE**
25	**Total costs [sum lines 17-24]**		**610,195**	
	Less: Total costs for services currently excluded from Reference Costs Collection		170,060	
	Total Reference Cost Submission Quantum		440,135	

N.B The starting point for costing will be the month 13 ledger download. Any significant audit adjustments should be reflected in the ledger download to ensure that reference costs reconcile to final accounts.

* If reported as part of 'Other Operating Income' in Final Accounts, please add back to line 5 & net off using line 6; please ensure costs are not netted off twice

** Adjustments for these lines should not incur any additional costs apportioned for lines 18 to 24 inclusive

*** RTA income should not be reported as Category C, therefore if it's included in line 5, it must be added back

**** Some items are not 'allowable' as Category C income for RC purposes. There is a separate file detailing such items. Please check with the central team if further clarification is required.

Due to differences in accounting practice, it is the responsibility of each organisation to ensure that where adjustments are made, are made in line with the above, no double counting occurs - i.e. no netting off / adding back of the same thing twice.

Note: where Provider-Provider agreements have been adjusted prior to determining in line 1, there is no requirement to either re-adjust or separately identify the adjustment in the 'ADJUSTMENT FOR PROVIDER-PROVIDER AGREEMENTS' line of the Reconciliation Statement.

NHS FOUNDATION TRUSTS

Table 2: Reconciliation of FTC data to Reference Costs for NHS Foundation Trusts.

Line Count		Line Reference	£	
1	Operating expenses [FTC0101]	120	705,781	
2	Less: Non NHS: Private Patients [FTC05A]	170	- 15,000	
3	Less: Non NHS: Overseas Patients [Non Reciprocal] [FTC05A]	180	- 3,450	
4	Less: Non NHS: Other [TAC05]	200	- 13,000	
5	Less: Other operating income [TAC01] [Please see Category C 'allowables' file]	110	- 239,855	
6	Less: Actual Cost of Distinction Awards [please identify separately]*		- 25,000	
7	Add: RTA income [Please Read Note] ***		52,000	
8	Less: RTA bad debts written off		2,100	
9	Add: items not allowable as Category C for RC [Please see Category C 'allowables' file]****		2,500	
10	Less: Actual Cost of Impairments **		- 65,000	
11	Add: Transfers from reserves in respect of impairments **		12,000	
12	Less: Actual Additional costs incurred as result of AfC Early Implementation **		- 65,000	
13	Less: Actual Funds received for Foundation Trust Application **		- 42,000	
14	Less: PFI Exclusions [Please see PFI Guidance file] **		- 30,000	
15	**Total Net Operating Expenditure:**		**276,076**	**REPORT LIN**
16	Adjustment for Provider-Provider Agreements [All Providers]		**- 35,000**	**REPORT LIN**
17	**Sub-Total**		**241,076**	
18	Add: Cost of fundamental reorganisation / restructuring [FTC0101]	140	-	
19	Add: (Profit) / loss on disposal of fixed assets [FTC01]	150	223	
20	Less: Interest receivable	170	- 125,444	
21	Add: Interest payable	180	65,320	
22	Add: PDC Dividends payable	220	325,544	
23	Add: Other finance costs - unwinding of discount	190	67,400	**REPORT LIN**
24	Add: Other finance costs - change in discount rate on provisions	215	36,076	**REPORT LIN**
25	**Total costs [sum lines 17-24]**		**610,195**	
	Less: Total costs for services currently excluded from Reference Costs Collection		170,060	
	Total Reference Cost Submission Quantum		440,135	

N.B Please note for FTs licenced part way through 2004/5, the TAC reconciliation will need to be used to obtain part of the reference cost quantum and the FTC reconciliation used to obtain the remaining element. Only one reference cost submission is required.

* If reported as part of 'Other Operating Income' in Final Accounts, please add back to line 5 & net off using line 6; please ensure costs are not netted off twice

** Adjustments for these lines should not incur any additional costs apportioned for lines 18 to 24 inclusive

*** RTA income should not be reported as Category C, therefore if it's included in line 5, it must be added back

**** Some items are not 'allowable' as Category C income for RC purposes. There is a separate file detailing such items. Please check with the central team if further clarification is required.

Due to differences in accounting practice, it is the responsibility of each organisation to ensure that where adjustments are made, are made in line with the above, no double counting occurs - i.e. no netting off / adding back of the same thing twice.

Note: where Provider-Provider agreements have been adjusted prior to determining in line 1, there is no requirement to either re-adjust or separately identify the adjustment in the 'ADJUSTMENT FOR PROVIDER-PROVIDER AGREEMENTS' line of the Reconciliation Statement.

- In addition, note that FRS 11 adjustments (per final accounts) should be excluded from Reference Costs - use line 10 for local reconciliation.

- Note that the above reconciliation may be revised when new TACs are issued early next year.
- Full details will be available on the Noticeboard section of the Discussion Forum.

Appendix 3 – Primary Care Trust Reconciliation to ASF figures

Table 1: Reconciliation of ASF data to Reference Costs for PCTs.

Line Count		Line Reference	£	
1	Operating expenses [ASF05]	100	705,781	
2	Less: Non NHS: Private Patients [ASF05]	190	- 15,000	
3	Less: Non NHS: Overseas Patients [Non Reciprocal] [ASF05]	210	- 3,450	
4	Less: Non NHS: Other [ASF05]	220	- 13,000	
5	Less: Other operating income [ASF05] [Please see Category C 'allowables' file]	270	- 239,855	
6	Less: Actual Cost of Distinction Awards [please identify separately]*		- 25,000	
7	Add: RTA income [Please Read Note] ***		52,000	
8	Less: RTA bad debts written off		2,100	
9	Add: items not allowable as Category C for RC [Please see Category C 'allowables' file]****		2,500	
10	Less: Actual Cost of Impairments **		- 65,000	
11	Add: Transfers from reserves in respect of impairments **		12,000	
12	Less: Actual Additional costs incurred as result of AfC Early Implementation **		- 65,000	
13	Less: PFI Exclusions [Please see PFI Guidance file] **		- 10,000	
14	**Total Net Operating Expenditure:**		**338,076**	**REPORT LINE AS 'TOTAL**
15	Adjustment for Provider-Provider Agreements [All Providers]		**3,500**	**REPORT LINE AS 'ADJUS'**
16	**Sub-Total**		**341,576**	
	The following relate to the Provider Share only:			
17	Add: Cost of fundamental reorganisation / restructuring		-	
18	Add: (Profit) / loss on disposal of fixed assets		223	
19	Less: Interest receivable		- 125,444	
20	Add: Interest payable		65,320	
22	Add: Other finance costs - unwinding of discount		67,400	**REPORT LINE AS PART O**
23	Add: Other finance costs - change in discount rate on provisions		36,076	**REPORT LINE AS PART O**
24	**Total costs [sum lines 17-23]**		**385,151**	
	Less: Total costs for services currently excluded from Reference Costs Collection		170,060	
	Total in Reference Cost submission		215,091	

N.B The starting point for costing will be the month 13 ledger download. Any significant audit adjustments should be reflected in the ledger download to ensure that reference costs reconcile to final accounts.

* If reported as part of 'Other Operating Income' in Final Accounts, please add back to line 4 & net off using line 5; please ensure costs are not netted off twice

** Adjustments for these lines should not incur any additional costs apportioned for lines 17 to 23 inclusive

*** RTA income should not be reported as Category C, therefore if it's included in line 4, it must be added back

**** Some items are not 'allowable' as Category C income for RC purposes. There is a separate file detailing such items. Please check with the central team if further clarification is required.

Due to differences in accounting practice, it is the responsibility of each organisation to ensure that where adjustments are made, are made in line with the above, no double counting occurs - i.e. no netting off / adding back of the same thing twice.

Note: where Provider-Provider agreements have been adjusted prior to determining in line 1, there is no requirement to either re-adjust or separately identify the adjustment in the 'ADJUSTMENT FOR PROVIDER-PROVIDER AGREEMENTS' line of the Reconciliation Statement.

- In addition, note that FRS 11 adjustments (per final accounts) should be excluded from Reference Costs - use line 10 for local reconciliation.

- Note that the above reconciliation may be revised when new ASFs are issued early next year.
- Full details will be available on the Noticeboard section of the Discussion Forum.

Appendix 4 – Category C Income 'Allowables'

With thanks to Sue Pilkington, Trent Costing Group & Many Many Others!	
Incomes classed as Category C	**Notes**
A&E Patient Experiance Fund	Not acceptable as category C : cannot net off
Access, Booking & Choice Funding	Not acceptable as category C : cannot net off
Advertising	Acceptable
Actual Additional costs incurred as result of AfC Early Implementation [April to September 2004]	Please exclude costs incurred [not net off income, as income received to date may not fully reimburse costs during financial year]
Agenda for Change income received for period [October 2004 to March 2005]	Not acceptable as category C : cannot net off [costs for this period should be included]
Beverages & Meals	Acceptable
Cancer Network	Acceptable
Cancer Services collaborative	Not acceptable as category C : cannot net off
Capital to Revenue Transfers	Not acceptable as category C : cannot net off
Car Park Income	Acceptable
Catering Income	Acceptable
Charitable contributions to non pay expenditure	Acceptable
CHD Collaborative	Not acceptable as category C : cannot net off
Clinical Audit Funding	Not acceptable as category C : cannot net off
Conference income	Acceptable
Consultant Distinction Awards	Acceptable [for RC purposes only]
Copy X Ray Income for legal cases	Acceptable
Copying/Photography Income	Acceptable
Court Order Admin Fee	Acceptable
Culyer income (R&D)	Acceptable
DOH funding for specific projects e.g. Disability equipment assessment	Not acceptable, unless targeted income specified in this listing
Drugs Income for drugs supplied to other Trusts and Pharmacists	Acceptable [expected to be Income from Operations - i.e. Category C]
Drug Trial Income	Acceptable, but associated activity must be excluded from RC [similar treatment to private patients]
Emergency Services Collaborative	Not acceptable as category C : cannot net off
External income - research	Acceptable
G.P. Co - Op Income	Acceptable [expected to be Income from Operations - i.e. Category C]
GH "Restroom" hospitality inc	Acceptable
GH "Restroom" takings	Acceptable
Hospital shop leases	Acceptable
I&E Surplus [from previous year]	Not acceptable as category C : cannot net off
Improvement Partnership for Hospitals	Not acceptable as category C : cannot net off
Income from "Safer Cities"	Depends on Income Source
Income from admin charges	Acceptable
Income From Charity And Others	Acceptable
Income from educational course	Acceptable
Income from hospitality	Acceptable
Income from investments	Acceptable
Income from Lifting	Acceptable
Income from moving & handling	Acceptable
Income from telephones	Acceptable
Income Generation schemes e.g. Use of pool & Physio gym	Acceptable
Information for Health	Not acceptable as category C : cannot net off
Information for Health Modernisation Fund	Not acceptable as category C : cannot net off
Interest received on cash deposits	Acceptable
Lease Car Income	Acceptable
Lecture fees income	Acceptable
Lodging charges	Acceptable
Maternity Liaison Committee	Not acceptable as category C : cannot net off
Misc Sale Of Inventory Items	Acceptable
Miscellaneous Income	Acceptable
Mortuary fees	Acceptable
OT sales	Acceptable
Paycare Commission	Acceptable
Planned in-year non recurrent support	Not acceptable as category C : cannot net off
Prescription income (Pharmacy)	Acceptable
PTP Handling charges	Acceptable
PTP income	Acceptable
PTP income VAT to pay	Acceptable
Receipts in Advance	Acceptable
Recharges to PCTs as contribution to expenditure for NHS Direct	Not acceptable as category C : NHS Direct excluded, therefore income shouldn't be netted off
Reclaims/Rebates	Acceptable
Rent & rates deductions	Acceptable
Rent of Land & Premises	Acceptable
Salary recharges to charities , Universities (e.g. for staffing university sessions on the Trusts MRI scanner), Other non NHS bodies eg Clinical pathology Accreditation	Acceptable [expected to be Income from Operations - i.e. Category C]
Sale of baby scan photos	Acceptable
Sale of Scrap	Acceptable
Silver recovery	Acceptable
Social services income Staff	Not acceptable : if pooled budget arrangements, service should be excluded from RC 2005
Staff meal deductions	Acceptable
Telephone income	Acceptable
Theatre & Pre-Op Assessment Programme	Acceptable to net off the funding received from the Modernisation Agency to fund the Project management costs of collecting & supplying data on theatre utilisation, etc. to DoH.
Training income (includes NVQ, NMET, SIFT, Madel, PGME, WDC)	Acceptable
Transfer from donated asset reserve to contra depreciation	Acceptable
Transitional Relief	Not acceptable as category C : cannot net off [It's essentially a negative cost]
Unclaimed Patients property	Acceptable
Vending Machine Sales	Acceptable
WHO income	Acceptable

- For Reference Costs purposes, Category C income (that can be netted off from the Quantum of Costs) is only **that relating to non-patient-related income;** income should not be netted off simply because it is targeted / specific funding.
- Where allowable category C income relates to services currently excluded from reference costs, care must be taken to ensure that category C income for those services is not netted off; there are no costs (in the submission) to 'match' this income to.

Appendix 5 – PFI Exclusions

HEADING	Comment	DH comments on treatment of costs for reference cost purposes.
Unitary Payment		Include
Volume Adjuster	For increases in patient related expdt	Include
Interim Services (incl Pass Thru Costs)	Hard and soft services transferred early	Include
Demolition Costs	Of building in way of new build	Exclude. If the scheme were to be funded through public capital this is likely to be capital expenditure.
LCIM - NHS Bank Claim	Project Co costs for ongoing maint./ replacement of variations, over life of project	
Advisor Fees	External to Trust	Exclude. To clarify the guidance, set up costs (principally fees) can be excluded up to the point of commissioning. If there is a staged programme please provide details to the ref costs mailbox for further clarification.
Project Team	Internal	Exclude. To clarify the guidance set up costs (principally fees) can be excluded up to the point of commissioning. Please make sure that you can satisfy the auditors that the costs of the project team do relate to the time spent working soley on the PFI scheme.
Clinical Sciences Building Running Costs		Include
Accelerated Depreciation		Exclude. Accelerated depreciation and impairments can be excluded but you should make sure that any income received should not be netted off.
Dual Running Costs	For services transferring	Include. Double running costs for all other service reconfigurations etc are included.
Medical Records Store	Not provided for in new build	Include

- As a general principle, PFI set up costs will include one off revenue costs incurred in setting up a PFI scheme from the initial business case stage to financial close. It will include largely fees (consultancy, legal, financial etc) and other costs such as planning applications.
- Queries regarding specific PFI costs should be sent to the reference costs mailbox; refcosts@doh.gsi.gov.uk, with a brief description of the costs involved.

OPCS Outpatient Procedure Mapping

Note that the following OPCS codes should be used to identify Outpatient Procedures reported separately in Reference Costs 2006.

RC Code	RC Narrative	OPCS 4 Code	OPCS 4 Narrative
OPAIJ1	Aspiration / Injection into Joint	W90.1 W90.3	Aspiration of joint Injection of therapeutic substance into joint
OPANG1	Angiography	K63.1 K63.2 K63.3 K63.4 K63.5 K63.6 K63.8 K63.9	Contrast radiology of heart, Angiocardiography of combination of right and left side of heart Contrast radiology of heart, Angiocardiography of right side of heart nec Contrast radiology of heart, Angiocardiography of left side of heart nec Contrast radiology of heart, Coronary arteriography using two catheters Contrast radiology of heart, Coronary arteriography using single catheter Contrast radiology of heart, Coronary arteriography nec Contrast radiology of heart, Other specified Contrast radiology of heart, Unspecified
OPAPT1	Apicectomy of Tooth	F12.1	Apicectomy of tooth
OPBCU1	Biopsy of Cervix Uteri	Q03.4 Q03.5 Q03.8 Q03.9	Punch biopsy of cervix uteri Ring biopsy of cervix uteri Biopsy of cervix uteri OS Biopsy of cervix uteri unspecified
OPBCY1	Bronchoscopy	E49.1 E49.9	Fibreoptic bronchoscopy & biopsy Diagnostic fibreoptic bronchoscopy, Unspecified
OPBVV1	Biopsy of Vulva	P09.1	Biopsy of lesion of vulva
OPCAR1	Carpal Tunnel Release	A65.1	Release of entrapment of peripheral nerve at wrist, Carpal tunnel release
OPCON1	Colonoscopy	H22.1 H22.8 H22.9	Diagnostic endoscopic examination of colon, Diagnostic fibreoptic endoscopic examination of colon and biopsy of lesion of colon Diagnostic endoscopic examination of colon, Other specified Diagnostic endoscopic examination of colon, Unspecified
OPCOP1	Colposcopy	P27.3 Q55.8 + Z45.1	Exploration of vagina, Colposcopy nec Other examination of female genital tract and Sit code cervix uterus
OPCRT1	Cataract Replacement	C75.1 C71.2	Insertion of prosthetic replacement for lens Phakoemusification of lens

RC Code	RC Narrative	OPCS 4 Code	OPCS 4 Narrative
OPCYY1	Cystoscopy	M45.1	Diagnostic endoscopic examination of bladder, Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder
		M45.2	Diagnostic endoscopic examination of bladder, Diagnostic endoscopic examination of bladder and biopsy of lesion of prostate
		M45.8	Diagnostic endoscopic examination of bladder, Other specified
		M45.9	Diagnostic endoscopic examination of bladder, Unspecified
OPDEL1	Diagnostic Endoscopic Examination of Larynx	E36.1	Diag endos exam of larynx and biopsy of lesion of larynx
		E36.8	Diagnostic endoscopic examination of larynx OS
		E36.9	Diagnostic endoscopic examination of larynx unspecified
OPDEP1	Diagnostic Endoscopic Examination of Pharynx	E25.1	Diag endos exam of nasopharynx and biopsy lesion nasopharyn
		E25.2	Diag endos exam of pharynx and biopsy lesion pharynx nec
		E25.3	Diagnostic endoscopic examination of nasopharynx nec
		E25.8	Diagnostic endoscopic examination of pharynx OS
		E25.9	Diagnostic endoscopic examination of pharynx unspecified
OPDMA1	Drainage of Middle Ear	D15.2	Suction clearance of middle ear
OPEPI1	Epidural Injections (for Pain Services, specifically not to be used for Obstetrics)	A52.1	Therapeutic epidural injection, Therapeutic lumbar epidural injection
		A52.2	Therapeutic epidural injection, Therapeutic sacral epidural injection
		A52.8	Therapeutic epidural injection, Other specified
		A52.19	Therapeutic epidural injection, Unspecified
OPFNB1	Fine needle biopsy of breast	B37.1	Other operations on breast, Aspiration of lesion of breast
		B32.1	Biopsy of breast, Percutaneous biopsy of lesion of breast
OPFSI1	Flexible Sigmoidoscopy	H25.1	Diagnostic endoscopic examination of lower bowel using fibreoptic sigmoidoscope, Diagnostic endoscopic examination of lower bowel and biopsy of lesion of lower bowel using
		H25.8	Diagnostic endoscopic examination of lower bowel using fibreoptic sigmoidoscope, Other specified
		H25.9	Diagnostic endoscopic examination of lower bowel using fibreoptic sigmoidoscope, Unspecified
OPHYS1	Hysteroscopy	Q18.1	Diagnostic endoscopic examination of uterus, Diagnostic endoscopic examination of uterus and biopsy of lesion of uterus
		Q18.8	Diagnostic endoscopic examination of uterus, Other specified
		Q18.9	Diagnostic endoscopic examination of uterus, Unspecified
OPLDL1	Laser Destruction of Lesion of Skin	S09.1	Photodestruction of lesion of skin, Laser destruction of lesion of skin of head or neck
		S09.2	Photodestruction of lesion of skin, Laser destruction of lesion of skin nec
OPMTM1	Medical Termination	Q11.4	Extraction of menses
OPNBP1	Needle biopsy of prostate	M70.1	Other operations on outlet of male prostate, Aspiration of prostate nec
		M70.2	Other operations on outlet of male prostate, Perineal needle biopsy of prostate
		M70.3	Other operations on outlet of male prostate, Rectal needle biopsy of prostate

RC Code	RC Narrative	OPCS 4 Code	OPCS 4 Narrative
OPRSI1	Rigid Sigmoidoscopy	H28.1	Diagnostic endoscopic examination of sigmoid colon using rigid sigmoidoscope, Diagnostic endoscopic examination of sigmoid colon and biopsy of lesion of sigmoid colon
		H28.8	Diagnostic endoscopic examination of sigmoid colon using rigid sigmoidoscope, Other specified
		H28.9	Diagnostic endoscopic examination of sigmoid colon using rigid sigmoidoscope, Unspecified
OPSIS1	Subcutaneous injection / introduction of substance into skin	X38.1	Subcutaneous injection, Injection of triamcinolone for local action
		X38.2	Subcutaneous injection, Injection of steroid for local action nec
		X38.3	Subcutaneous injection, Injection of hormone for local action nec
		X38.4	Subcutaneous injection, Subcutaneous chemotherapy
		X38.5	Subcutaneous injection, Subcutaneous immunotherapy
		X38.6	Subcutaneous injection, Subcutaneous injection for local action nec
		X38.8	Subcutaneous injection, Other specified
		X38.9	Subcutaneous injection, Unspecified
OPSRT1	Surgical Removal of Tooth	F09.1	Surgical removal of impacted wisdom tooth
		F09.2	Surgical removal of impacted tooth nec
		F09.3	Surgical removal of wisdom tooth nec
		F09.4	Surgical removal of tooth nec
		F09.5	Surgical removal of retained root of tooth
		F09.8	Surgical removal of tooth OS
		F09.9	Surgical removal of tooth unspecified
OPUDS1	Urodynamic Studies	M47.8 + Y44.2	Other specified urethral catheterisation of bladder; Monitoring of pressure in organ noc
OPUGE1	Upper Gastro Endoscopy	G45.1	Diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract, Fibreoptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion
		G45.8	Diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract, Other specified
		G45.9	Diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract, Unspecified

Reference Costs 2006 : Summary of Key Changes

Please note that the following points do not constitute a comprehensive list of changes to the Reference Costs 2006 guidance and subsequent collection. Rather, they are reflective of those that will have the most impact on the NHS organisations providing Reference Costs 2006 data.

Overview

- ⇨ The main purpose of the Reference Costs collection is to provide information to be used in the calculation of the national tariff. Data quality is therefore paramount, in both cost and activity terms.
- ⇨ The national tariff will be on a spell basis, for inpatient admissions. However, unit cost and activity for Reference Costs 2006 will continue to be on an FCE basis, although spell activity data will form part of this collection, as in previous years.
- ⇨ The Reference Costs 2006 collection will use version 3.5 HRGs.
- ⇨ All cost data will be reported in pounds and pence. Published information will continue to be produced in pounds, except for the high volume low cost areas of direct access.

Admitted Patient Care (Section 2)

- ⇨ The 2006 collection uses the revised national specialty list as detailed in DSCN 34/2003, issued in July 2003, effective from 1st April 2004 combined with additional sub-specialty classifications where deemed necessary and appropriate.
- ⇨ FCE activity for unclassified (U code) data will continue to be required in order to complete the collection files, as in 2005. (Note that as in 2005, U code data is not included in the calculation of the Reference Cost Index for an organisation.)
- ⇨ Excess bed day activity and unit cost per excess bed day, for Version 3.5 HRGs, will also be required, as in previous years.
- ⇨ Ward attender data is no longer required to be reported separately, but rather, should be included in the composite unit costs and activity of outpatient attendances.

Critical Care Services (Section 3)

- ⇨ CCS data must be reported for discrete units only, rather than on an individual bed basis.
- ⇨ As in 2005, counting of critical care services occupied bed days should follow the NHS 'midnight count' protocol. This means that an occupied bed day is only counted as such where a patient is occupying the bed at midnight.
- ⇨ Memorandum activity for ACP is required for all discrete CCS units in 2006. No cost data is required for ACP bed / cot day data.
- ⇨ For all forms of adult intensive care / high dependency units, data is required using a classification relating to 'levels of care' (per the CCMDS) (paragraph 37 refers). There is no option to report 'no detailed data available' in 2006.
- ⇨ A new distinct category for 'Liver Intensive Care Units' has been added in 2006.

Paramedic Services provided by Ambulance NHS Trusts (Section 5)

- ⇨ A new category for the Out of Hours service (where NHS ambulance provider has taken over the responsibility of providing this service from GPs, and where the service is commissioned by PCTs) is introduced in the analysis of 'Other 999 Calls'.

Outpatients (Section 7)

- ⇨ The 2006 collection uses the revised national specialty list as detailed in DSCN 34/2003, issued in July 2003, effective from 1st April 2004 combined with additional sub-specialty classifications where deemed necessary and appropriate.
- ⇨ An optional collection relating to non-face to face contacts has been included in 2006 for the first time for outpatient activity (paragraph 121 refers).
- ⇨ Costs and activity data for an extended list of specified procedures undertaken in an outpatient setting are required to be separately reported in 2006 (paragraph 142 refers).
- ⇨ A new category of Dietetics has been introduced in 2006.

Mental Health Services (Section 8)

- ⇨ Child category now split between 'drug & alcohol' and 'other'.
- ⇨ DNA activity collected as separate activity memorandum item for outpatients on collection files, and community services on Statement Z. DNA activity cannot be included as valid activity in 2006, but will be separately identified to provide more comparative data on which to understand costs.
- ⇨ Child & Adolescent Secure Units introduced for three designated units only (paragraph 158 refers).
- ⇨ A new category for 'Dangerous and Severe Personality Disorder' is introduced for Maximum secure Units only.
- ⇨ Single MHST category is revised, and is now split across 12 distinct categories (paragraph 175 refers).
- ⇨ The single day care category for Mental Health Services is split across 3, distinguishing between Child, Adult and Elderly patients (paragraph 183 refers).

Audiology Services (Section 9)

- ⇨ Digital Hearing Aid services remain **excluded** in 2006 for all NHS Trusts, including NHS Foundation Trusts.

Therapy Services (Section 10)

- ⇨ The category for therapy services direct access has been superceded by the outpatient category for therapy services (paragraphs 136, 200 and 202 refer).
- ⇨ For community-based services, the categories for adult and child have been split between one-to-one activity, and group activity. [Note that this split is required for clinic-based services – i.e. outpatients – on Statement Z].
- ⇨ The activity basis for reporting data remains **total contacts in the financial year** / **total group contacts in the financial year**.

Community / Outreach Nursing Services (Section 11)

- ⇨ Activity and unit cost data for all community / outreach nursing services will continue to be split between face-to-face and non-face-to-face data, however **the reporting of non-face-to-face total contacts in the financial year data remains OPTIONAL in 2006**.
- ⇨ A new category in 'Community Medical Services: Other Services' is introduced for Community Paediatrician activity.

Other Specialist Services (Section 12)

Renal Dialysis

- ⇨ This service is split between adult and child for the first time in 2006.

Radiotherapy

- ⇨ Radiotherapy HRGs are to be used for the **treatment** costs of radiotherapy services only. Non-treatment costs, including ward costs, etc. should be reported using the appropriate version 3.5 HRG and relevant locally determined specialty.
- ⇨ As in 2005, the collection currency for Radiotherapy is the number of individual treatments (or fractions) in the financial year, **not the number of courses of treatment.** A single patient undergoing 6 fractions will thus be reported as **6** in the **relevant HRG category. This change reflects the fact that collecting courses rather than individual patient treatment activity can distort cost variation in service delivery.**

Chemotherapy

- ⇨ Chemotherapy services include both oral and intravenous chemotherapy, but only include chemotherapy that is solely for the treatment of cancer.
- ⇨ Chemotherapy classification groups are to be used for the **treatment** costs (i.e. drug, associated drug and pharmacy oncosts) of chemotherapy services only. Non-treatment costs, including ward costs, etc. should be reported using the appropriate version 3.5 (*98) HRG and relevant locally determined specialty.
- ⇨ In 2006, the collection currency for Chemotherapy remains as the number of individual patient treatment attendances for chemotherapy in the financial year, **not the number of drug regimens.** A single patient attending for 8 chemotherapy treatments will thus be reported as **8** in the **relevant classification group category. This change has resulted from concerns about the lack of**

consistency and comparability in drug 'regimen' data, and the need for a locally meaningful, clearly defined and nationally understood collection category for these services.

⇨ Chemotherapy Services continue to **include chemotherapy for the treatment of non-solid tumours**.

Services Accessed Directly (Section 13)

⇨ The definition of 'direct access' has been extended to include referrals by all healthcare and other professionals, rather than just GPs.

⇨ Two new categories for radiology services have been added, for PET Scans and DEXA Scans.

⇨ The number of physiological measurements tests has been extended and refined (paragraph 315 refers).

⇨ The category for direct access dietetics has been superceded by the outpatient category (paragraphs 136 and 316 refer).

Reconciliation Statements & Statement Z

⇨ The automated reconciliation statements introduced in 2004 have been retained in 2006, with few changes (although some of the more obscure validation rules on the 2005 Statement PSS1 will be removed for 2006).

- As a general rule, the signs on the reconciliation statement PSS1 are the reverse of those on the TAC / FTC / ASF. All costs, and increases in costs, should be shown as positives, whereas all income (profit) and reduction to costs should be shown as a negative.

⇨ Statement Z, has also been retained, and extended to include a greater range of detail applicable to PbR. Full details of Statement Z for 2006 will be available in early February 2006, before the release of the 2006 collection files, anticipated in April 2006.

- As in 2005, it is acceptable that organisations include additional items on Statement Z, although the underlying premise of this statement will remain the same, i.e. it provides details of the costs that have been included in Reference Costs submissions, but may be separately identified if necessary for further analysis and investigation.
- Note that Statement Z now forms part of the mandatory collection files for 2006, and is auditable. It is vital that this statement is completed, in order to assist in tariff calculation.

⇨ Note that it is intended to release the first draft of the 2006 Reference Costs Statement Z as part of the 2006 guidance, in October 2005.

Statement Z

⇨ Where activity for drugs costs are separately identified, these are patient-based (i.e. not no. of scripts).

⇨ Re: **Standard length of time for drug prescription on patient discharge**. Where organisations have no standard, but the above differs by specialty, organisations can either:

- Calculate a weighted standard based on the total activity for all directorates
- Disregard this line and add additional lines to indicate differing lengths for different directorates.

Reference Costs 2006 : Points to Note
[Issued Previously in the Frequently Asked Questions Documents Issued in 2005]

Pooled / Unified Budgets (including Section 31 Agreements) – reiteration of current treatment

⇨ As a general principle, **the costs and activity for any and all services jointly provided under Pooled / Unified Budget arrangements with Agencies outside the NHS** (e.g. Social Services, Housing, Employment, Education, etc.) **are to be excluded** from the Reference Costs 2005 collection **in their entirety** (i.e. both NHS and non-NHS elements of expenditure and activity).

⇨ Where organisations are confident that they ;
- can separately identify a discrete element of the service that is funded by the NHS, &
- that they can identify the total costs incurred by that service; &
- have accurate and reflective activity data,

they can choose to include that service. Such decisions should be defendable to Auditors.

Recording a Service which is Part Funded by Two Different Organisations, for example, an NHS Trust and a Primary Care Trust - Clarification

⇨ The overriding principle for Reference Costs is total absorption costing, so one organisation [either the Trust or the PCT] has to report the full cost of this service, and it ideally should be the organisation that holds clinical responsibility for the patients. E.g. for direct access radiology, if the Trust provide the staff, etc, and the PCT pays for the machine, we would expect that if the patients 'belong' to the PCT, they reimburse the Trust for the costs that it incurs. The Trust would therefore net off this [provider-provider] income, and the PCT would report the entire costs [direct + what they pay the Trust] and the whole activity in the appropriate collection category – e.g. banding if the service is accessed directly by patients.

⇨ Where the split between costs and activity is not so straightforward, e.g. where the PCT and Trust enter into a partnership arrangement where each pays half of some service or other, the organisation which holds clinical responsibility for the patients should report the total costs and activity, and the other organisation should not report anything for this service.
- E.g. If a service costs £10m in total, for scanning for 10,000 patients, for whom the PCT are clinically responsible, and the Trust incurs costs of £1m in providing the service, [which the PCT does not reimburse the Trust for,] then the PCT needs to report the unit cost as being £10m/10,000 = £1,000 / scan, and the Trust reports nothing. Although this will not be the way that the expenditure is reported in final accounts, Reference Costs only have to reconcile to final accounts figures, not balance exactly. Of course, this only works if the PCT agree to 'take' the £1m from the Trust for Reference Costs reporting purposes...

⇨ But if the PCT do not, they will be artificially lowering the unit cost of the scan, and not reporting using full absorption costing, which contravenes the principles as laid out in the NHS Costing Manual.

Outpatients

⇨ **Outpatient Attendances: Consultant and Nursing Activity**
- As a general principle, the same patient should not be counted twice for attending the same clinic at the same time.
- Where nurses / technicians are providing support to a consultant, in a single clinic, and where the patient only has a single appointment for a specific clinic, we would not expect such activity to be counted as a separate and distinct attendance for Reference Costs outpatient clinic activity.
- Where a patient has two booked appointments, e.g. with a consultant and with a nurse, this should be counted as two attendances, where the attendances are for two discrete clinics, even if they're on the same day / in the same general location.

⇨ **Using the New Therapy Outpatient Categories**
- Where a patient attending a clinic sees a therapist as part of that clinic attendance, the costs of such therapy should be included as part of the composite cost of that outpatient attendance.
- Where a patient attends a discrete therapy clinic and the sole reason for that attendance is to receive therapy treatment, this should be reported as a therapy outpatient attendance using the appropriate category.

Valid Activity

⇨ **Valid Non-Face to Face Activity**

- Only non-face to face activity with a patient where such activity is in place of a face to face contact can be rightly counted as valid activity.
- This therefore means that all activity about a patient, rather than with a patient, is not valid for Reference Costs purposes.

⇨ **Meetings About a Patient**

- If the meeting with a patients' relatives is a proxy for a meeting with a patient, this CAN be counted as valid activity.
- Similarly, if ordinarily a patient would attend the meeting, but for some reason they cannot, the meeting with relatives in their stead can be deemed valid.
- However, as a general principle, non-patient activity isn't valid for RC purposes.

Clinical Trials

⇨ If the impact of income for clinical trials is such that to nett it off would produce unrealistically low, zero or negative costs (i.e. surplus income), the costs and activity relating to such trials must be excluded).

⇨ Clinical trial costs and activity should only be included where the costs incurred are an accurate indication of what the actual costs of that treatment would be, outside the clinical trial setting.

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* The NHSIA Casemix Service is transferring to a new special health authority in April 2005, the Health and Social Care Information Centre. Business continuity will be assured in assessing Casemix tools during this migration.