Volume 6: National Cost Collection – community sector

February 2020

NHS England and NHS Improvement

Contents

1. Introduction

1.1 Purpose

1. This document forms part of the 2020 National Cost Collection (NCC) guidance which is being published in volumes.

2. You should have read *Volume 1: Overview* before reading this document.

3. You should have also read *Volume 2: National Cost Collection reconciliation and exclusions*.

4. The mandated collection for the community sector in 2020 is aggregated healthcare resource group (HRG)/currency costs.[1] Changes to this collection are minimal in 2020 to allow providers to continue on their Costing Transformation Programme (CTP) journey by implementing PLICS for the pilot collections this year.

1.2 Context

5. Volume 6 is for trusts that primarily provide community services and describes the collection process for submitting their activity and cost data in the NCC workbook for the period 1 April 2019 to 31 March 2020.

6. Trusts that mainly provide acute, ambulance or mental health services should read their sector's equivalent volume. These volumes include guidance on how to submit costs for any community services outside their core mandated sector.

[1] The term NCC average costs has replaced the term reference costs.

1.3 What's new for the community sector in 2020?

7. While keeping changes to a minimum, we do endeavour to reduce burden where possible by developing the collection documentation, support, tools and user experience

Table 1: Changes for the community sector

Area of change	Description
Guidance documents	Produce guidance documentation tailored to the sector and its mandated submission.
AUD worksheet	All audiology activity and cost should be submitted on a new dedicated worksheet within the NCC workbook.

2. Scope of activity and costs to be collected in 2020

1. Table 2 lists the worksheets in the NCC workbook for the costs of services to be collected from the community sector in 2020. They are marked with a tick (✓). Worksheets are not included for the costs of services that are not to be submitted by the community sector this year and are marked with a cross (×).[2]

2. Please note that for the community sector cystic fibrosis drugs and high-cost devices remain as excluded items in the National Cost Collection and therefore should be on the reconciliation.[3]

Table 2: Worksheets included in the 2020 community NCC workbook

NCC worksheets	Inclusions and exclusions for 2020
AE (accident and emergency)	✓
AUD (audiology) (**new**)	✓
CHS (community health services)	✓
Day case	✓
DA (direct access)	✓
HCD (high-cost drugs)	✓
IMAG (imaging)	✓
IP (inpatients)	✓

[2] If your organisation thinks it should submit a service not included in the 2020 NCC workbook, please contact costing@improvement.nhs.uk FAO NCC team before 30 April 2020.
[3] The acute sector is submitting these at patient level for the first time in 2020.

NCC worksheets	Inclusions and exclusions for 2020
MH (mental health)	✓
OPATT (outpatient attendance)	✓
OPROC (outpatient procedure)	✓
Reconciliation	✓
REHAB (rehabilitation services)	✓
Sensitive/legally restricted (**new**)	✓
SPAL (specialist palliative care)	✓
AMB (ambulance)	×
CC (critical care)	×
CF (cystic fibrosis)	×
Chemo & radiotherapy	×
CMDT	×
RENAL (renal dialysis)	×
Checklist (removed)	N/A

3. Community services

11. This section focuses on those services that are submitted on the CHS worksheet.

3.1 Activity estimation in community sector

12. Not all community providers have fully automated systems. Therefore:
    - they may use appropriate sample data to ascertain annual activity when reporting information in this section
    - no minimum sample time is stipulated but the sample should reflect annual activity in a service area
    - if this is not feasible, providers may use informed clinical estimates.[4]

13. The services described in this section may be provided in various locations/settings in the community, such as a patient's home, clinics, community hospitals, GP practices or health centres.

14. Where a care contact starts in one costing period and ends in another (eg for night care), the start date determines if it should be included in the cost collection, not the end date.

3.2 Community care in an acute setting

15. Some services may be provided in or by acute hospitals. All costs should be submitted under CHS unless these services are provided as part of an admitted patient care (APC) episode or outpatient attendance. If the latter, the costs should be reported within the composite cost of the APC or outpatient attendance HRG.

16. Specialist or acute staff may attend patients in community settings. This reflects the less clearly defined service boundaries in the new models of health service delivery. For several services, this can mean staff who provide services on wards in acute hospitals also do so in other settings to give

[4] Evidence of the data source should be retained.

patients continuity of care. You should work towards using the dataset recorded as the defining location for the activity – as within the Community Services Data Set (CSDS)/Commissioning Data Set (CDS) description above.

3.3 Definition of outpatient versus community care contact

17. There is no Information Standard Notice (ISN)[5] defining the difference between an outpatient attendance and a community care contact. As defined in Community standard CM3: Non-admitted patient care,[6] a healthcare professional travelling to a community location (eg the patient's home) to see one patient should be treated as a community contact for costing. This is recorded on the CSDS. Where a clinician travels to a community location to see more than one patient in a planned session, this should be treated as one of the following:
    - if recorded on the CSDS: a community care contact and reported on the CHS worksheet
    - if recorded on the CDS: an outpatient attendance and reported on the OPATT worksheet.

3.4 Community services definitions

18. The currency for community services is the number of care contacts[7] within the costing period unless otherwise stated.

19. The following should be treated as an overhead to the service, and therefore not counted:
    - did not attend (DNA)
    - meetings held between clinical staff about the patient but not involving the patient or their proxy

[5] Issued by NHS Digital, ISNs are published to announce new or changes to information standards published under section 250 of the Health and Social Care Act 2012.
[6] https://improvement.nhs.uk/resources/approved-costing-guidance-2020/
[7] www.datadictionary.nhs.uk/data_dictionary/classes/c/care_contact_de.asp?shownav=1

- telephone contacts and telemedicine messages solely to inform a patient of their results.

20. Where both the patient and relative/carer are present, one patient contact should be recorded.[8]

21. Only non face-to-face contacts[9] by care professionals that directly support diagnosis and/or care planning and replace a face-to-face contact should be included in the collection.

22. The activity measure for group sessions is the number of patients in the group. If two clinicians deliver a group session for 10 patients, each clinician records 10 contacts for that group, and 20 contacts should be reported for that session.

3.5 Allied health professionals

23. The 2020 NCC will cover activity provided by the following allied health professionals (AHPs), subdivided into adult/child and group/one-to-one currencies:[10]

- dietitians
- occupational therapists
- physiotherapists
- podiatrists
- speech and language therapists
- other therapists not listed above.[11]

[8] For example, if a health visitor sees the parent, child or both; this should be recorded as one contact.

[9] www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1

[10] www.datadictionary.nhs.uk/data_dictionary/attributes/c/card/care_professional_staff_group_for_community_care_de.asp?shownav=1

[11] A full list of therapist types can be found in the NHS Data Dictionary: www.datadictionary.nhs.uk/data_dictionary/attributes/c/card/care_professional_type_de.asp?shownav=1

3.6 Podiatry

24. The currencies for community podiatry services are:[12]

    - tier 1: General podiatry
    - tier 2: Minor surgery
    - tier 3: Complex foot disease
    - specialist care 1
    - specialist care 2
    - other non-core podiatry.

25. Podiatry services provided in a hospital outpatient setting or another acute provider setting should be recorded on the CHS worksheet using the more descriptive currencies above, and not on the OPATT worksheet. This makes the costing of podiatry services consistent and comparable irrespective of the sector providing them.

26. Nail procedures performed by a podiatrist in an outpatient setting and grouping to the JC43 HRGs should be reported on the OPROC worksheet and not the OPATT worksheet or the CHS worksheet.

3.7 Audiology

27. This section covers audiology attendances[13] and services delivered within discrete audiology departments.[14] Audiology costs in 2020 will be collected on a single worksheet in the NCC workbook.

28. This section should be read alongside the new Standard CM22: Audiology services within the integrated costing methods.[15]

29. The currencies are outlined in **Table 3** below.

[12] A full definition of the currencies can be found in the *Costing glossary*.
[13] www.datadictionary.nhs.uk/version2/data_dictionary/classes/a/amb/audiology_attendance_de.asp?sho
[14] See Standard CM22: Audiology services for more information.
[15] https://improvement.nhs.uk/resources/approved-costing-guidance-2020/

Table 3: Audiology currencies

Audiology currency code	Currency description	Comments
AS01	Fitting of hearing aid, adult	The unit cost is per fitting.
AS02	Fitting of hearing aid, child	
AS03	Fitting of hearing aid, child, specialist audiology services	
AS04	Fitting of hearing aid or device for tinnitus	
AS05	Hearing aid, adult, any qualified provider contract	Costs of repairs, moulds, tubes, etc should be included in the fitting or aftercare services rather than against the actual hearing aid.
AS06	Hearing aid, adult, other contract	
AS07	Hearing aid, child	
AS08	Follow-up, adult, face to face	AS08
AS09	Follow-up, child, face to face	AS09
AS10	Follow-up, non face to face	AS10
AS11	Implant aftercare	The unit cost is per event of aftercare.[16]
AS12	Maintenance and programming, bone anchored hearing aid	
AS13	Maintenance and programming, cochlear implant	

[16] The cost may include cleaning advice; cleaning aids; battery removal or replacement for patients with limited dexterity; replacement of tips, domes, wax filters and tubing; required replacement or modification of ear moulds; repair or replacement of faulty hearing aids on a like-for-like basis; and provision of patient information. The separate currencies covering the maintenance and programming of bone-anchored hearing aids (BAHAs) and cochlear implants are not part of the CA39*, CA40* or CA41* HRG costs, which are the HRGs for surgical implantation.

Audiology currency code	Currency description	Comments
AS14	Rehabilitative audiology service, one to one	
AS15	Rehabilitative audiology service, group	
ASNNS	Newborn hearing screening programme attendance	
CA37A	Audiometry or hearing assessment, 19 years and over	Providers should report activity using these codes as cost per hearing assessment.
CA37B	Audiometry or hearing assessment, between 5 and 18 years	
CA37C	Audiometry or hearing assessment, 4 years and under	
CA43Z	Balance assessment	

Newborn hearing screening

30. You should report the unit cost per NHS newborn hearing screening programme attendance.

31. The costs of interventions resulting from these screening attendances should be included as part of the composite APC or outpatient cost against the appropriate HRG and **not** in the CHS worksheet.

Other audiology services

32. Audiology departments provide a range of rehabilitative services, eg auditory processing disorders, communication groups, environmental aids sessions, lip reading, relaxation classes and vestibular rehabilitation therapy. If their costs do not fit with any of the other currencies in this section, they should be included against one of the following currencies:

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

- rehabilitative audiology services (group) – the unit per group session.

33. The following HRGs should be reported on the new AUD worksheet only:
    - CA38A Evoked potential recording, 19 years and over
    - CA38B Evoked potential recording, 18 years and under
    - CA39Z Fixture for bone-anchored hearing aids
    - CA40Z Fitting of bone-anchored hearing aids
    - CA41Z Bilateral cochlear implants
    - CA42Z Unilateral cochlear implant.

3.8 Daycare facilities

34. Daycare facilities[17] for older, stroke and other patients are included in the NCC. Facilities for patients with learning disabilities are excluded for community and acute service providers in 2020.[18]

35. The unit cost is per patient day, counted to half days where applicable.

36. Often patients attend these facilities for a number of days each week, but the number will vary with the of their conditions. Generally, the number of places each day is fixed, eg 20 patients each day over five days equates to 100 patient days, or one patient attending one day per week for 20 weeks equates to 20 patient days. When summing your total activity, you need to make a conversion from a part day attendance to a patient day for patients attending for only part of a day, eg a morning only attendance equals 0.5 patient days (see example in Table 4).

[17] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?shownav=1

[18] See Volume 5: National Cost Collection Guidance – mental health sector for the inclusion of day care for patients with learning disabilities in the NCC.

Table 4: Summing daycare attendance activity

Patient A	Attends 3 half days in financial year 2019/20	1.5
Patient B	Attends 1 full day in financial year 2019/20	1
Patient C	Attends 1 full day and 5 half days in financial year 2019/20	3.5
	TOTAL	**6**

* Therefore, the total activity to be submitted in the NCC workbook is six days. Totals with half days (eg 6.5) should rounded up to the nearest full day.

3.9 Single condition community rehabilitation teams

37. This section is for single condition community rehabilitation teams (such as stroke or neuro rehabilitation teams), which are excluded from intermediate care and do not meet the definitions for the unbundled rehabilitation HRGs.

38. Community rehabilitation teams usually include healthcare professionals providing ongoing care to patients in a community setting. The services include nursing and a range of therapy services, but exactly which are provided will depend on a patient's needs. Teams may operate from both hospital and community bases, but this has no relevance to the submission. Care must be taken not to double-count any activity reported using the unbundled rehabilitation HRGs.

39. The activity measure is the number of team contacts in a financial year – for example, one patient seen by a nurse for three days, twice by a physiotherapist and twice by a speech and language therapist represents seven team contacts.

40. This example assumes that team members only see patients on a team basis. Therefore, regardless of which members of the team (even if only one team member) are present for the attendance, in terms of activity the attendance counts as one team attendance.

41. Where members of a clinical team also see patients in another capacity (eg as a speech and language therapist), costs and activity should not be reported as part of the community rehabilitation team activity but elsewhere in the collection using the relevant currency, eg community speech and language therapy.

42. The collection for community rehabilitation teams is categorised as one of:

- stroke community rehabilitation teams
- neuro community rehabilitation teams
- other single condition community rehabilitation teams.

3.10 Intermediate care

43. Intermediate care[19] is a range of integrated services for adults aged 19 and over that are time-limited to six weeks maximum. The services promote faster recovery from illness/surgery; prevent unnecessary acute hospital admission and premature admission to long-term residential care; support timely discharge from hospital; and maximise independent living.

44. Services are predominantly provided by healthcare professionals in multidisciplinary teams (led by a senior clinician) who develop an intermediate care plan for each patient.

45. Services that can contribute to the intermediate care function include:

- rapid response teams including admission avoidance schemes[20]
- residential rehabilitation in a setting such as a residential care home or community hospital
- supported discharge or support in a patient's own home
- day rehabilitation.

[19] http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

[20] Admission avoidance schemes regardless of location should be included in crisis response.

46. Where a service is provided to patients with conditions covered by the mental healthcare clusters (MHCCs), the costs and activity should be included in the MHCCs.[21]

47. The intermediate care currencies are:

- crisis response services
- home-based services[22]
- bed-based services.

48. These currencies **exclude** the following services which should be reported on the reconciliation statement[23] and their activity ignored:

- NHS continuing healthcare and NHS-funded nursing care
- reablement services
- intermediate care delivered to children aged under 18.

49. These currencies also exclude the following services which should be submitted elsewhere in the community NCC workbook as described:

- early supported discharge in hospital – as an overhead to the appropriate APC HRGs
- single condition rehabilitation (eg stroke) – on the REHAB tab in the NCC workbook
- non-specialist stroke and neuro rehabilitation services – under the relevant community rehabilitation category
- mental health crisis resolution services, rehabilitation or intermediate care – on the MH tab in the NCC workbook
- general community hospital beds not designated as intermediate care – on the APC tab in the NCC workbook
- general district or specialist nursing services[24] – on the CHS worksheet in the NCC workbook.

50. Intermediate care services are typically jointly commissioned by the clinical commissioning group and local authority. Pooled or unified budgets are

[21] Mental Health Services in this document
[22] Early supported discharge in the home should be included in home-based services.
[23] See *Volume 2: National Cost Collection reconciliation and exemptions*.
[24] Including community matrons or active case management teams.

sometimes excluded from the NCC average costs (see Annex 1 in *Volume 1: Overview*), but you are encouraged to identify and include activity and costs for all the discrete healthcare elements of the intermediate care service the NHS provides.

3.11 Medical and dental services

Community dental

51. Community dental services are for patients who have difficulty getting treatment in their 'high street' dental practice and who need to be referred for treatment. The currencies for community dental services are:

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

52. In each case the unit is per care contact – regardless of the units of dental activity (UDA) that may be counted in that contact.

3.12 Health visitors and midwifery

53. **Error! Reference source not found.**5 lists the currencies for health visitors and midwives.

54. Currencies for health visitors are consistent with the Healthy Child Programme.[25]

[25] www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

55. N03G and N03J include safeguarding, child assessment frameworks, child protection meetings, children in need, looked-after children, serious case reviews and supporting families with complex needs. They also include public health contacts (clinics, children's centres and early-years settings).

56. Family nurse partnership (FNP) programmes will be collected separately to other health visitor contacts. You should continue to report immunisations separately at full cost (including travel costs), on the same basis as they report school-based children's services.

57. **Note:** Home births should be submitted using the relevant HRG in the CHS worksheet in the NCC workbook.

Table 5: Health visitor and midwifery currencies

Health visitor and midwifery currency codes	Currency description
N03A	Health visitor, antenatal review (1h)
N03B	Health visitor, new baby review (2h)
N03C	Health visitor, 6 to 8 week check (1h)
N03D	Health visitor, 1 year review (1h)
N03E	Health visitor, 2 to 2.5 year review (2h)
N03F	Health visitor, other clinical intervention (to provide parenting support on specific issues, eg breast feeding, postnatal depression)
N03G	Health visitor, other statutory contact, face to face
N03J	Health visitor, other statutory contact, non-face to face
N03N	Health visitor, immunisation
N03P	Family nurse partnership programme visit
N03PC	Parentcraft
N01A	Community midwife, antenatal visit

Health visitor and midwifery currency codes	Currency description
N01P	Community midwife, postnatal visit
NZ16Z	Antenatal routine observation
NZ17A	Antenatal false labour, including premature rupture of membranes, with CC score 2+
NZ17B	Antenatal false labour, including premature rupture of membranes, with CC score 0–1
NZ18A	Antenatal complex disorders with CC score 2+
NZ18B	Antenatal complex disorders with CC score 0–1
NZ19A	Antenatal major disorders with CC score 2+
NZ19B	Antenatal major disorders with CC score 0–1
NZ24A	Antenatal therapeutic procedures, including induction, with CC score 2+
NZ24B	Antenatal therapeutic procedures, including induction, with CC score 0-1
NZ25Z	Labour without specified delivery
NZ30A	Normal delivery with CC score 2+
NZ30B	Normal delivery with CC score 1
NZ30C	Normal delivery with CC score 0
NZ31A	Normal delivery with epidural or induction, with CC score 2+
NZ31B	Normal delivery with epidural or induction, with CC score 1
NZ31C	Normal delivery with epidural or induction, with CC score 0
NZ32A	Normal delivery with epidural and induction, or with post-partum surgical intervention, with CC score 2+
NZ32B	Normal delivery with epidural and induction, or with post-partum surgical intervention, with CC score 1
NZ32C	Normal delivery with epidural and induction, or with post-partum surgical intervention, with CC score 0

Health visitor and midwifery currency codes	Currency description
NZ33A	Normal delivery with epidural or induction, and with post-partum surgical intervention, with CC score 2+
NZ33B	Normal delivery with epidural or induction, and with post-partum surgical intervention, with CC score 1
NZ33C	Normal delivery with epidural or induction, and with post-partum surgical intervention, with CC score 0
NZ34A	Normal delivery with epidural, induction and post-partum surgical intervention, with CC score 2+
NZ34B	Normal delivery with epidural, induction and post-partum surgical intervention, with CC score 1
NZ34C	Normal delivery with epidural, induction and post-partum surgical intervention, with CC score 0
NZ40A	Assisted delivery with CC score 2+
NZ40B	Assisted delivery with CC score 1
NZ40C	Assisted delivery with CC score 0
NZ41A	Assisted delivery with epidural or induction, with CC score 2+
NZ41B	Assisted delivery with epidural or induction, with CC score 1
NZ41C	Assisted delivery with epidural or induction, with CC score 0
NZ42A	Assisted delivery with epidural and induction, or with post-partum surgical intervention, with CC score 2+
NZ42B	Assisted delivery with epidural and induction, or with post-partum surgical intervention, with CC score 1
NZ42C	Assisted delivery with epidural and induction, or with post-partum surgical intervention, with CC score 0
NZ43A	Assisted delivery with epidural or induction, and with post-partum surgical intervention, with CC score 2+

Health visitor and midwifery currency codes	Currency description
NZ43B	Assisted delivery with epidural or induction, and with post-partum surgical intervention, with CC score 1
NZ43C	Assisted delivery with epidural or induction, and with post-partum surgical intervention, with CC score 0
NZ44A	Assisted delivery with epidural, induction and post-partum surgical intervention, with CC score 2+
NZ44B	Assisted delivery with epidural, induction and post-partum surgical intervention, with CC score 1
NZ44C	Assisted delivery with epidural, induction and post-partum surgical intervention, with CC score 0

3.13 Parentcraft

58. Parentcraft classes are multidisciplinary and may include health visitors, community midwives and other healthcare professionals. The cost should include that for all staff present. Parentcraft classes are group sessions and the unit of activity is the number of pregnant women attending the group.[26]

3.14 Nursing

Specialist nursing services[27]

59. Specialist nursing services are disaggregated by the bands in **Error! Reference source not found.**, split further by adult or child and face-to-face or non face-to-face.

Table 6: Specialist nursing service bands

[26] Fathers and birthing partners should not be counted in the number attending.
[27] You should make every effort to map district nursing services to the appropriate specialist nursing bands. Only if this is not possible, or the care provided is standard district nursing, should you report against district nursing, split by face-to-face and non face-to-face.

National code	Description	Comment
N06	Active case management (community matrons)	
N07	Arthritis nursing/liaison	
N08	Asthma and respiratory nursing/liaison	
N09	Breast care nursing/liaison	
N10	Cancer related	
N11	Cardiac nursing/liaison	
N12	Children's services	See paragraph 60
N14	Continence services	Exclude costs relating to regular delivery of supplies (eg continence pads, stoma bags) direct to the patient. These should be reported on the reconciliation template.
N15	Diabetic nursing/liaison	
N16	Enteral feeding nursing services	
N17	Haemophilia nursing services	
N18	HIV/AIDS nursing services	Includes follow-up of HIV care, psychosocial support, treatment support for individuals starting or switching therapy, etc.
N19	Infectious diseases	
N20	Intensive care nursing	
N21	Palliative/respite care	
N22	Parkinson's and Alzheimer's nursing/liaison	
N24	Stoma care services	See comment against N14: Continence services.

National code	Description	Comment
N25	Tissue viability nursing/liaison	
N26	Transplantation patients nursing service	Includes patients on pre and post-transplantation programmes.
N27	Treatment room nursing services	To be used by nursing staff based in GP surgeries.
N28	Tuberculosis specialist nursing	
N29	Other specialist nursing	Eg sickle cell

3.15 Community services for children, including nursing[28]

60. As well as specialist nursing services, the NHS provides a range of other nursing services for children, including:
    - vulnerable children support, including child protection and family therapy
    - development services for children, including psychology
    - paediatric liaison
    - other child nursing services not included in specialist nursing and school-based child health services, including looked-after children nurses.

61. These services should be reported as one composite group using the activity measure of total community contacts in the NCC average cost year.

3.16 Child protection services[29]

62. The following should be noted for child protection services:[30]
    - the cost of child protection is a support cost to all services for children

[28] Community consultant-led paediatric services should be reported on the OPATT worksheet in the NCC workbook under TFC 290, not in the CHS worksheet.
[29] This applies to all child protection teams, including those with consultants and nurses as members.
[30] These services are separate from those performed by community paediatricians.

- included activity should relate to the number of total face-to-face contacts, not the number of children on the register
- funding from non-NHS bodies should be netted off incurred expenditure
- the cost of advisory services where there is no contact with children should be apportioned between the service areas that receive advice
- activity relating to meetings about the patient is not counted for NCC average costs and should be treated as an overhead.

3.17 School-based children's health services

63. Several health services and checks are delivered in educational facilities. School-based children's health services include all services provided in the school setting, not just school-based nurses. Community paediatricians may also contribute to these. For NCC average costs, school-based services are spilt into:

- **core services**[31] which are divided into one-to-one, group single professional and group multiprofessional
- **other services** which are divided into one-to-one, group single professional, group multiprofessional
- **vaccination programmes:** the unit cost is average per vaccination. Two vaccinations from a course of three given in the year counts as two, which allows incomplete courses to be recorded. You need to appreciate that the average costs of at least four different vaccination programmes are collected[32]
- **special schools nursing:** the unit of activity is a patient contact.

3.18 Wheelchair services[33]

64. Wheelchair services are spilt into two categories:

- needs-based currencies for non-complex wheelchair services covering assessment, equipment, review, and repair and maintenance

[31] Including school entry review and year 6 obesity monitoring.
[32] Fluenz, Men ACWY, school leaver booster and HPV.
[33] Please see Community standard CM19: Wheelchair services for more information.

- specialised complex wheelchair services commissioned by NHS England and NHS Improvement, which should be separately reported on the basis of unit cost per registered user.

65. They are further spilt between adults (aged 19 and over) and children (up to and including 18 years).

66. Table 7 explains the currencies and gives definitions and examples.

Table 7: Wheelchair currencies, definitions and examples

Cat code	Unit	Activity	Definition	Examples
WC01	Per episode of care	Low need – assessment	Limited need allocation of clinical time. Most of the activity expected to fall into this category. Can be met through telephone triage or review of referral materials provided by a competent referrer.	Occasional user of wheelchair user with relatively simple needs that can be readily met. Do not have postural or special seating needs. Physical condition is stable or not expected to change significantly. Assessment does not typically require specialist staff (generally self-assessment or telephone triage supported by health/social care professional or technician). Limited (or no) requirement for continued follow-up/review.
WC02		Medium need – assessment	A higher allocation of clinical time to conduct a comprehensive assessment for the prescription of a manual chair, including an allocation of time to both therapist and rehabilitation engineer.	Daily user of wheelchair or use for significant periods on most days. Have some postural or seating needs. Physical condition may be expected to change (eg weight gain/loss, some degenerative conditions). Comprehensive, holistic assessment by skilled assessor required. Regular follow-up/review.
WC03		High need – manual assessment	This currency involves a higher allocation of clinical time than the medium currency. This also includes the use of staff who have a higher and more specialist skill set. A longer assessment to allow a comprehensive assessment for the prescription of a power chair,	Permanent users who are fully dependent on their wheelchair for all mobility needs. Physical condition may be expected to change/degenerate over time. Very active users requiring ultra-lightweight equipment to maintain high level of independence. Initial assessment for all children.
WC04		High need – powered assessment		

Cat code	Unit	Activity	Definition	Examples
			including an allocation of time for both therapist and rehabilitation engineer.	Comprehensive, holistic assessment by skilled assessor required. Regular follow-up/review with frequent adjustment required/expected.
WC05	Per chair issued (delivery of a complete 'equipment package' of the wheelchair, necessary cushions, seating systems, belts or harnesses, modifications and accessories with activity selected based on the highest level of accessory issued)	Low need – equipment	A basic wheelchair package that includes a standard cushion and one accessory and modification.	Equipment requirements – basic wheelchair (self or attendant propelled. Standard cushion, up to one accessory and up to one modification.
WC06		Medium need – equipment	A higher allocation of equipment and modifications.	Equipment requirements – configurable, lightweight or modular wheelchair (self or attendant propelled). Low-to-medium pressure-relieving cushions, basic buggies, up to two accessories and up to two modifications.
WC07		High need – manual equipment	More complex and customised.	Equipment requirements – complex manual or powered equipment including tilt-in-place or fixed-frame chairs, seating systems of different chassis, high pressure-relieving cushions, specialist buggies, multiple accessories, multiple and/or complex modifications and needs are met by customised equipment.
WC08		High need – powered equipment		
WC09	Per registered user per year	All needs – manual repair and maintenance (R&M)	The tariff has assumed that services will be outsourced to another organisation.	The unit cost for each chair can be calculated using the total R&M budget against activity for the period. Allocation of costs to these currencies should be made on the basis of: • parts and labour for repair of wheelchairs

Cat code	Unit	Activity	Definition	Examples
WC10		All needs – powered R&M		• delivery or collection of chairs to or from users • costs associated with scrapping chairs at end of their useful life • annual planned preventive maintenance for power-chair users. In calculating the average R&M unit cost per chair, use a combination of low, medium and high needs categorisation. This only applies to manual wheelchairs.
WC11	Per review	All needs – review	This involves the review of a patient.	This could be planned or via an emergency route when the patient's condition or equipment changes. A review that results in the patient being provided with additional equipment or modification incurs a separate charge.
WC12	Per item	All needs – review substantial	A review following a modification/new accessory or resulting in a completely new follow-up assessment if a new wheelchair is required. These specialist modifications (without supply of the chair) should be included in this category. The unit of activity should be the number of chairs modified (regardless of the number of modifications included).	All needs – review substantial accessory (a review of existing equipment issued to the service user followed by a minor modification/onward referral to R&M/new accessory – cushion or seat backs). If (as arising from the review) a completely new assessment or new wheelchair is required, this is recorded in the assessment and equipment pathways as a new episode of care. It may include: • chair • cushioning • accessories • wheelchair therapies and/or rehabilitation engineer/technician time to perform modifications to the chair and fitting of accessories

Cat code	Unit	Activity	Definition	Examples
				• clinical time associated with checking of modifications and handover of equipment.
WC13	Per review	Specialised complex wheelchair services	More complex and customised.	A higher allocation of equipment modifications. Cost per chair, not per modification.
WC14		Equipment, specialist modification without supply	This involves a review of the patient.	A higher allocation of equipment and modifications. Seating systems on different chassis/high pressure-relieving cushions/specialist buggies/multiple accessories/multiple and/or complex. Wheelchair not supplied.

4. Other services[34]

4.1 Emergency departments (including A&E, minor injury units and walk-in centres)[35]

67. In 2019, NHS Digital's Emergency Care Data Set (ECDS) for urgent and emergency care replaced the Accident and Emergency CDS previously used to collect information from emergency departments (EDs) across England.

68. All activity from 1 April 2019 must be reported using CDS 6.2.2 Type 011 ECDS.

69. ED attendances are categorised as follows:

- department type:[36]
  - EDs (national code 01)
  - consultant-led monospecialty A&E services (national code 02)[37]
  - other types of A&E (national code 03) which include minor injury units (MIUs) and urgent care centres
  - NHS walk-in centres (national code 04)
- healthcare resource group (HRG) – VB emergency care
- post-ED pathway:
  - patients who are admitted for further investigation or treatment rather than discharged from A&E
  - patients who are not admitted but are discharged or die while in A&E.

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

[34] The following guidance is for services provided by the community sector that are not submitted on the CHS worksheet in the NCC workbook.
[35] See Acute standard CM4: Emergency department attendances.
[36] www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp
[37] May be 24-hour or non 24-hour.

71. Costs and activity for MIUs should be reported separately only if the MIU is:
    - discrete, and the attendance is instead of, and has not already been counted as, an A&E attendance
    - not discrete, but sees patients independently of the main ED.

72. A&E mental health liaison services should be reported as cost per patient contact on the MH worksheet in the NCC workbook using the currency MHSTAEA or MHSTAEC, not in the A&E worksheet.

73. The costs of activity typically unbundled from attendances, eg diagnostic imaging, should be included in the core A&E HRGs. The grouper determines a single HRG for each A&E attendance record.

74. Patients brought in dead (A&E patient group code 70)[38] should be coded, costed and submitted against HRG VB99Z – patient dead on arrival.

4.2 Admitted patient care

75. This section covers the following types of admitted patient care (APC):
    - daycase electives[39]
    - ordinary electives[40,41]
    - ordinary non-electives[42]
    - regular day or night admissions.[43]

76. Community providers must submit their APC costs by finished consultant episode (FCE), treatment function code (TFC) and HRG.

77. The HRG4+ 2018/19 reference cost grouper being used in 2020 attaches a core HRG to every FCE.

[38] www.datadictionary.nhs.uk/data_dictionary/attributes/a/a_and_e_patient_group_de.asp?shownav=1
[39] www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1
[40] www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1
[41] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/e/elective_admission_de.asp?shownav=1
[42] All national codes excluding 11, 12 and 13 at www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1
[43] www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1

78. You only report core HRGs on the DC or IP worksheets in the NCC workbook, and the costs of unbundled HRGs separately on the HCD, REHAB or SPAL worksheets.

79. Regular day or night admissions[44] are reported on the DC worksheet in the NCC workbook.

Ordinary non-elective short stays and long stays

80. All ordinary non-elective activity must be separately identified as long or short stay by completing the input fields required by the grouper for critical care, rehabilitation and specialist palliative care length of stays. On processing the inpatient non-elective activity through the grouper, it deducts these days from the core stay.

81. A short stay is one day. The grouper automatically adds one day to admissions with a zero day length of stay. All other stay lengths are long (number of inlier bed days plus excess bed days divided by the number of FCEs).

Excess bed days and trim points

82. Community providers that submit APC activity should use the trim points included in the HRG4+ 2018/19 grouper and supporting documentation to calculate HRG length of stay and associated excess bed days, and submit these in the NCC workbook.

83. The cost per day for excess bed days must only include costs associated with the excess bed days. Unbundled costs must be excluded from the excess bed-day costs.

84. Generally, patient care is less intensive during the excess bed days than at the beginning of the FCE and as a result costs for these days are less than those for the inlier bed days.

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

Therapy services in admitted patient care

85. Where these services form part of an APC episode or outpatient attendance in a different specialty, the costs are part of the composite costs of that episode or attendance.

4.3 Outpatient services

86. This section covers:

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

87. Outpatient attendances and procedures in outpatients should be reported by HRG and TFC currencies at average cost by HRG and TFC.

88. The grouper may attach one or more unbundled HRGs to the core HRG produced. Only core attendances should be reported on the OP worksheet in the NCC workbook.

89. Unbundled HRGs should be reported separately in the appropriate worksheet in the NCC workbook.

90. Refer to Community standard CM3: Non-admitted patient care for the acute costing methods.[45]

Outpatient attendances

91. Outpatient attendances[46] in HRG4+ (WF01* and WF02*), generated from a number of mandated fields in the outpatient CDS, are organised by:

- first and follow-up attendance[47]
- face-to-face and non face-to-face attendance
- single and multiprofessional attendance

[45] https://improvement.nhs.uk/resources/approved-costing-guidance-standards
[46] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/o/out-patient_attendance_consultant_de.asp?shownav=1
[47] Follow-up attendances are classified as such regardless of whether the first attendance was in a previous financial year or not.

- advice and guidance.
- consultant-led and non consultant-led[48] in accordance with the mandatory outpatient attendance CDS type 020.[49]

92. Where a patient sees a healthcare professional in an outpatient clinic for a consultation, this counts as valid outpatient activity regardless of whether or not they receive any treatment during the attendance. NHS providers offer outpatient clinics in a variety of settings and these should all be included in the NCC where the cost is part of your operating expenditure.

93. The NCC does not distinguish between attendances that are pre-booked and those that are not.

94. The patient is recorded under the same TFC (eg a physiotherapist assessing an orthopaedic patient) regardless of whether they see the clinician they were referred to another healthcare professional.

95. A patient attending a ward for examination or care is counted as an outpatient attendance if they are seen by a doctor. If seen by a nurse, they are counted as a ward attendance. Costs and activity for ward attendances should be reported as non consultant-led outpatient attendances under the appropriate TFC.

96. Where single professionals see a patient consecutively as part of the same clinic, this should be reported as two separate attendances.[50]

97. Telephone contacts and telemedicine messages solely to inform patients of results are excluded.

98. Where you cannot distinguish between face-to-face and non face-to-face activity, you should report all costs for a particular TFC as face-to-face activity only.

[48] Consultant-led[48] activity occurs when a consultant retains overall clinical responsibility for the service, team or treatment. They do not necessarily need to be present.
[49] Clinics run by GPs with a special interest, or specialist therapists, normally take patients from what would have been a consultant list and are classed as consultant-led activity.
[50] As a first and a follow-up attendance if the healthcare professionals are in the same team, and two first attendances if they are in different teams.

99. No requirement stipulates that only those patients who have had a face-to-face contact can be counted as having subsequent non face-to-face contacts.

Outpatients without patient present

100. Outpatient activity is only valid if it entails direct contact with the patient or with a proxy for the patient, such as the parent of a young child.

101. A contact with a proxy only counts if it is instead of contact with the patient, and the proxy can ensure more effectively than the patient that the specified treatment is followed.

102. Meetings between clinical staff about the patient but **not involving the patient** or their proxy should not be recorded as a care contact. Costs should be treated as an overhead to the service.

103. Advice and guidance conversations with GPs where commissioned separately are an exception to this rule. The costs of contacts **about** the patient should be treated as an overhead to the service.

Multiprofessional attendances

104. Multiprofessional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time and when two or more of these professionals are consultants from different main specialties.

105. This definition applies when a patient benefits in terms of care and convenience from accessing the expertise of two or more healthcare professionals at the same time. The clinical input to multiprofessional or multidisciplinary attendances must be shown in the clinical notes or other documentation.

106. It does not apply:
    - if one professional is simply supporting another, clinically or otherwise
    - where a patient sees single professionals consecutively as part of the same clinic.

107. Multidisciplinary meetings should not be recorded as multidisciplinary attendances.

Therapy services in outpatients

108. Where patients have been referred directly to a therapy service, such as physiotherapy (TFC 650), occupational therapy (TFC 651), speech and language therapy (TFC 652), dietetics (TFC 654) and orthotics (TFC 658), by a healthcare professional including a GP, or have self-referred, and are seen in a discreet therapy clinic solely for the purpose of receiving treatment, the attendances should be submitted on the OP worksheet under the TFC denoting the therapy service.

5. Unbundled activity

121. Where there is zero or minimal cost to be allocated against a core HRG as a result of unbundling costs, you can exclude the core HRG and include all costs against the unbundled HRGs in the NCC workbook.

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

123. The grouper outputs a core HRG, and an unbundled rehabilitation HRG accompanied by a multiplier showing the days of rehabilitation within the FCE. The grouper adjusts the core length of stay for this activity.

124. No attempt should be made to separately identify non-discrete rehabilitation costs during an APC stay. Unbundled rehabilitation HRGs should not be used to describe the cost of activity beyond an HRG trim point for any acute or non-specified HRG.

5.1 Rehabilitation[51]

125. Rehabilitation enables a patient to improve their health status. Patients receive medical attention which results in an unbundled HRG from an admission or outpatient attendance.

126. Unbundled rehabilitation should be reported under one of the following settings:

- APC: average unit cost per occupied bed day
- outpatient: average unit cost per attendance
- other (regular day attenders): average unit cost per day.

[51] This section does not cover intermediate care, single condition community rehabilitation or rehabilitation that is part of a mental health event.

127. Each setting is further divided as follows:

- Complex specialised rehabilitation services (CSRS) – level 1:
  - delivered by specialist NHS providers
  - increased use of resources and longer length of stays
  - CSRS that fall within this definition set and contain components relating to admitted patient rehabilitation are:
    (1) specialised spinal services (all ages)
    (2) specialised rehabilitation services for brain injury and complex disability (adult)
    (3) specialised burn care services (all ages)
    (4) specialised pain management services (adult).
- Specialist rehabilitation services – level 2:
  - not designated as level 1
  - British Society of Rehabilitation Medicine (BSRM) has developed criteria and checklists for identifying level 2 services that conform to the standards required of a specialist rehabilitation service
  - have the following characteristics:
    (1) multidisciplinary team of staff
    (2) consultant with specialist accreditation
    (3) more complex caseload
    (4) meets the national standards for specialist rehabilitation laid out by the appropriate royal college and specialist societies
    (5) serves a recognised role in education, training and published research for development of specialist rehabilitation in the field.
- Non-specialist rehabilitation services – level 3:
  - any service that is not level 1 or 2.

128. **Community hospitals** should note the following:

- Those providing a rehabilitation service not reported on the CHS worksheet should report this on an occupied bed-day basis by HRG.
- Those providing rehabilitation services should submit this data using clinical coding or rehabilitation HRG allocation to the rehabilitation episode (because that is the service being provided), rather than using the acute

HRG that relates to the condition for which the patient was treated by the acute provider.

- Where patients are admitted to a community hospital after discharge from an acute provider (ie a different organisation), they should be assigned the appropriate rehabilitation HRG unless they are still receiving acute care and stabilisation.
- Where patients are transferred from an acute to a community hospital while at an acute stage of treatment to facilitate early discharge, but still require acute care and stabilisation before rehabilitation treatment, you should report the acute phase of care using an appropriate specialty and HRG, and report the rehabilitation using the appropriate unbundled rehabilitation services category.

5.2 Specialist palliative care

129. The unbundled specialist palliative care HRGs should be reported against the following settings:
    - ordinary elective or non-elective admissions, including support hospital teams
    - day cases and regular day or night admissions
    - outpatients
    - other.

130. This care should usually be reported using the main specialty codes for palliative medicine (315), nursing episode (950) or allied health professional episode (960).

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

132. You may need to talk to your specialist palliative care team to acquire local data feeds or contact information, as the informatics department may not collect this.

Table 8: Specialist palliative care currencies

SPC currency code	Currency description
SD01*	Specialist palliative care for ordinary elective or non-elective admissions should be reported per bed day.
SD02*	Same-day specialist palliative care; it may be day case or regular day or night attenders. The grouper automatically adds one bed day.
SD03*	If a patient is not admitted under the care of a specialist palliative medicine consultant but is receiving support from a member of a specialist palliative care team. The activity and costs submitted should be for face-to-face and non face-to-face support contacts between the specialist palliative care team and the patient, including any advice and guidance contacts between the specialist palliative care team and the doctor or nurse responsible for the patient's care.
SD04*[52]	Consultant-led non-admitted patient care (NAPC).
SD05*[53]	Non consultant-led NAPC.

5.3 Diagnostic imaging

133. Diagnostic imaging is unbundled from the attendance cost and should be reported separately when it is provided in the following settings:
    - outpatients first/follow-up attendances
    - direct access
    - other (eg regular day/night attendances).

134. The unit cost is per examination.

135. Diagnostic imaging should not be reported separately when it is provided in an APC setting. Similarly, the costs of diagnostic imaging in critical care,

[52] An additional core outpatient attendance should not be reported when a patient attends for specialist palliative care only
[53] An additional core outpatient attendance should not be reported when a patient attends for specialist palliative care only

rehabilitation or specialist palliative care should be included in the unbundled critical care, rehabilitation or specialist palliative care HRG.

136. Not all diagnostic imaging generates an unbundled diagnostic imaging HRG. For example, a correctly coded obstetric ultrasound in outpatients is likely to group to one of the obstetric medicine core HRGs. If an unbundled HRG is not created, then costs and activity for these scans should not be unbundled but reported within the generated core HRG.

137. Plain film X-rays do not have an unbundled HRG. When they are provided in A&E, APC or outpatient settings, their costs should be included in the core attendance. When directly accessed, they should be reported separately.

138. Diagnostic imaging should be reported by the TFC of the outpatient clinic from which the imaging was requested. Use TFC 812 if you cannot assign a TFC accurately.

5.4 High-cost drugs[54]

139. The medicines listed on worksheet 13b of Annex A of the 2020/21 tariff workbook[55] should be classed as 'high-cost drugs' (HCDs). These medicines should not form part of the unit costs for the NCC core HRG/unit and should be submitted by drug and point of delivery on the HCD worksheet in the NCC workbook.

140. The cost of procurement, prescribing and issuing the drug should be part of the core attendance/episode costs.

5.5 High-cost devices

141. The devices on worksheet 13a of Annex A of the 2020/21 tariff workbook[56] should be excluded from the core attendance/episode costs and reported on the reconciliation statement.

[54] Homecare medicines should be excluded in 2020.
[55] https://improvement.nhs.uk/resources/national-tariff/
[56] https://improvement.nhs.uk/resources/national-tariff/

6. Direct access services[57]

137. This section covers the following direct access services:
    - diagnostic services
    - pathology services.

138. Diagnostic or pathology services undertaken during APC, outpatients or A&E are included in the composite cost of this care.

139. These services should be submitted at aggregate level under workbook tab DA.

140. Costs and activity for the direct access services should be submitted based on the number of tests.

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

[57] See Standard CM23: Direct access and hosted programmes

7. Mental health services

142. This section covers:

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

143. The currencies for most mental health services for working-age adults and older people are mental healthcare clusters (MHCCs). This guidance should be read alongside Monitor and NHS England's *Guidance and mental health currencies and payment*.[58]

144. To understand what allocation of mental health services should be included in the NCC average costs, see Annex 1.

7.1 Adult mental health services

Mental healthcare clusters

145. The MHCCs for working-age adults and older people focus on the characteristics and needs of a patient under the three broad diagnostic categories of organic, psychotic and non-psychotic, rather than the individual interventions they receive or their specific diagnosis. The patient's cluster is derived from a mental health professional's code using the mental healthcare clustering tool (MHCT).[59]

146. The clusters cover extended time periods that often contain multiple different care interventions. Each cluster has an associated review period, defined as the time between reassessments. You should take this as a **maximum rather**

[58] www.gov.uk/government/uploads/system/uploads/attachment_data/file/300864/Guidance_to_mental_health_currencies_and_payment.pdf

[59] Providers must use the MHCT and corresponding MHCT booklet to help inform the clustering decision. The information captured must be returned with other data as part of the monthly submission to the Mental Health Minimum Data Set (MHSDS).

than a minimum period. However, if there is to be a reassessment before the maximum review period ends, because the patient's condition changes, this becomes the actual cluster review period for that patient.

Table 9: Cluster maximum review period

Code	Cluster label	Cluster review period (maximum)
00	Variance – unable to assign MHCC code	6 months
01	Common mental health problems (low severity)	12 weeks
02	Common mental health problems (low severity with greater need)	15 weeks
03	Non-psychotic (moderate severity)	6 months
04	Non-psychotic (severe)	6 months
05	Non-psychotic (very severe)	6 months
06	Non-psychotic disorders of over-valued ideas	6 months
07	Enduring non-psychotic disorders (high disability)	Annual
08	Non-psychotic chaotic and challenging disorders	Annual
09	Blank cluster[60]	Not applicable
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder (difficult to engage)	6 months

[60] Cluster 09 is not in the NCC workbook.

Code	Cluster label	Cluster review period (maximum)
18	Cognitive impairment (low need)	12 months
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical need or engagement)	6 months
IA98	Patient assessed but not accepted into service	N/A
99	Patients not assessed or clustered	N/A

147. The MHCC worksheet includes separate lines for:

- Unable to assign MHCC code (cluster 00): record costs for a patient who has been assessed and accepted for treatment but has not been allocated to a cluster, including the cost of their initial assessment on the initial assessment worksheet.
- Patients not clustered or assessed (cluster 99): record costs incurred for treatment before a patient has been fully assessed and allocated to a cluster. This will include costs close to the year-end where the initial assessment costs fall into both years and the cluster is allocated after the year-end. We do not want to include part-year costs in initial assessments, so initial assessment costs before and after the year-end will remain in cluster 99 in service code MHCCIA.
- IA98: patient assessed but not accepted into service: this line should be used for patients whose assessment has been completed and they have been discharged without treatment. These patients may have been inappropriately referred to mental health services or referred for a clinical opinion only.

Costing mental healthcare clusters

148. Mental health providers should cost their services using the costing principles set out in the *Approved Costing Guidance*[61] and the mental health costing standards.[62]

149. The key to accurate costing at cluster level is having the activity and interventions recorded by patient and the cluster allocated appropriately. This means costs can be built up by patient and then by cluster.

150. Where integrated teams include social workers, their costs and activity should only be included in the cluster costs if they are NHS-funded posts. All providers should include the costs of community teams' contacts with inpatients within the non-admitted cluster costs.

151. The initial assessment period begins when a mental health provider receives a new referral from a GP or elsewhere. The activity count for initial assessments is number of patients assessed.

152. Experience to date suggests that the initial assessment is normally completed within two contacts or on admission to an inpatient setting. The assessment is completed when the individual is either allocated to a cluster, admitted to a ward or not allocated – for example, discharged (cluster IA98). Therefore, we do not expect providers to have any inpatient costs within the initial assessment charge; however, we are aware that in some providers, initial assessment does occur in an inpatient setting. While a patient would normally be allocated to a cluster within two community contacts, this is not always the case and providers should include in the initial assessment charge all the costs of contacts up to and including the contact where the cluster is allocated, regardless of how many contacts this may be.

153. Once a patient has been assessed and placed in a cluster, the cost of the initial assessment is coded to the correct cluster in service code mental healthcare contact initial assessment (MHCCIA), not MHCC.

[61] See *The costing principles*: https://improvement.nhs.uk/resources/approved-costing-guidance/
[62] https://improvement.nhs.uk/resources/approved-costing-guidance-2019/

154. Clusters in service code MHCC should only include costs and activity incurred for a patient who has been allocated to a cluster. Costs and days incurred before clustering are allocated to the appropriate cluster in service code (MHCCIA).

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

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

Days in the cluster

157. Unit costs are per cluster per day, not per completed cluster, due to the length of time a patient may be within a cluster.[63]

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

- APC
- NAPC, covering outpatients, day care and community, and defined as the difference between the total number of cluster days and the number of cluster days in APC. To avoid double-counting, each cluster day can only be counted in one location for that day.

159. You should take care to ensure that the quantum is equal to the total cluster day costs and the initial assessment costs.

160. Annex 2 summarises the data we will collect for the MHCCs and an example cluster cost calculation is given in Annex 3.

[63] Produced using the length of clusters falling in the costs year, expressed in days, similar to an acute spell or episode, and the costs of interventions within them.

161. The count of days in the cluster begins from the day the patient is allocated to a cluster and continues through to the date the patient is discharged from the services or is allocated to another cluster on review. It includes days on a waiting list for treatment.

162. The number of occupied bed days in the cluster includes days when an inpatient may be on leave in the community.

163. The number of complete review periods and their average length should be returned in the memorandum columns. Where a review period is part-completed during the year, it should not be included. The intention is not to remove work in progress from the cluster cost, and you must provide costs for the full period of care in the financial year. A review period of 12 months (clusters 07 to 13) is likely to cross two financial years, and should be reported as one review of 365 days unless the patient is discharged or changes cluster within the year, in which case the actual length of time on the cluster (since first cluster or last review) should be included.

7.2 Improving Access to Psychological Therapies (IAPT)

164. The currency for IAPT clusters is cost per completed episode. The IAPT collection continues to be on a separate sheet to the main MHCC costs because IAPT services are distinct mental health services and in some areas are delivered by different organisations.

165. All IAPT activity recorded through the IAPT minimum dataset should be reported on the MHCCIAPT worksheet. IAPT contacts use the same cluster definitions as other mental health contacts but we expect most IAPT patients to fall into clusters 01 to 08 (with some falling into 00 or 99).

166. Like the main MHCC collection, we will collect separate costs for the initial assessment of a patient before their acceptance into services and the costs of treatment by cluster. The definition of the initial assessment period is the same as for the main collection.

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

Table 10: Summary of data collected for IAPT services

Field	Comments
Cluster costs IAPT mental healthcare cluster (service code IAPTMHCC)	
Unit cost per completed episode	The average unit cost of providing treatment to patients on the cluster (including the costs of episodes either not started or not completed in the financial year).
Total number of completed episodes	The total number of episodes of care completed (closed) during the financial year.
Memorandum information	
Number of contacts – high intensity	The total number of high intensity contacts provided to patients on the cluster (including the contacts relating to episodes either not started or not completed in the financial year). The definition of high intensity/low intensity contacts is taken from the IAPT Minimum Data Set (high intensity – therapy types 40 to 51).
Number of contacts – low intensity	The total number of low intensity contacts provided to patients on the cluster (including the contacts relating to episodes either not started or not completed in the financial year). The definition of high intensity/low intensity contacts is taken from the IAPT Minimum Data Set (low intensity – therapy types 20 to 29).
Total number of cluster days	The total number of days spent on IAPT care clusters completed (closed) during the financial year.
Average length of episode[64]	The average length of episode in days from first cluster to discharge. For a completed episode that began in the previous financial year, this will include the number of days in the cluster in the previous financial year as well as those in the current one.
Average number of contacts per episode	The average number of contacts in each episode.

[64] The method for calculating the average length of an episode is the same as that for calculating the average time in a cluster

Field	Comments
IAPT mental healthcare cluster initial assessment (service code IAPTMHCCIA)	
Unit cost per initial assessment	This covers the costs and activity associated with initial assessments of patients, which helps clinicians to allocate them to clusters. Initial assessment and clustering of patients can require significant professional resource, and are therefore identified separately rather than included as a support cost for patients who are clustered.
Number of initial assessments	

168. The total number of completed episodes is made up of those episodes where the patient was discharged during the financial year, including episodes started in the previous financial year.

169. The number of contacts relates to contacts with the patient only – either face-to-face or by telephone[65] where appropriate.

170. Where a patient attends a group, each patient counts as a contact for that group session. Where two staff members run a group, each patient counts as two contacts for that group session. Only contacts with staff members within your cost quantum should be counted.

171. We do not anticipate that the IAPT cluster costs will include any inpatient costs. Where a patient transitions between mental health and IAPT, a new cluster should be counted at the point the patient moves between services. It initiates an initial assessment in the receiving service.

172. We are aware that some providers cannot accurately cost the initial assessments for IAPT and that recording movement between IAPT clusters is difficult. Please record this information to the best standard that you can.

173. As we need to maintain the contact information, please ensure you still accurately record it on the MHCCIAPT worksheet, including a unit cost for your activity.

[65] Telephone contact must replace a face-to-face contact.

7.3 Non-cluster activity (CAMHS, drug and alcohol, specialist mental health)

Table 11: Non-cluster activity (CAMHS, drugs and alcohol, specialist mental health)

Service	Settings	Subcategories
Child and adolescent mental health services[66]	• Admitted patient care • Daycare facilities on a patient-day basis • Outpatient attendances • Community contacts	• CAMHS, admitted patients, psychiatric intensive care unit • CAMHS, community contacts, crisis resolution home treatment
Drug and alcohol services for patients without a significant mental health need	• Admitted patient care • Outpatient attendances • Community contacts	
Specialist mental health services	• Admitted patient care • Outpatient attendance • Community contacts	• Adult specialist eating disorder services • Child and adolescent eating disorder services • Gender identity disorder services • Mental health services for deaf children and adolescents • Mental health services for veterans • Specialised services for Asperger's syndrome and autism spectrum disorders (all ages) • Specialist mental health services for deaf adults

[66] Child and adolescent, drug and alcohol, IAPT, eating disorder and secure services are reported separately.

Service	Settings	Subcategories
		• Specialist perinatal mental health services (inpatient mother and baby units and linked outreach teams) • Other specialist mental health inpatient services

Settings for non-cluster activity

Ordinary elective and non-elective admissions (APC)

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

175. You should ensure that the reported total number of occupied bed days for a ward does not include any leave-day activity unless the bed is held open for that patient to return to, ie that no other patient uses the bed in their absence. This rule also applies to patients transferred temporarily to an acute provider for treatment.

176. Costs and activity for mental health services provided in daycare facilities[67] should be submitted on the same basis as for other patients using these facilities.

177. Daycare facilities usually have consultant input and undertake patient assessments, whereas a community mental health team group contact does not necessarily involve a consultant and patient assessments.

[67] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/day_care_facility_de.asp?shownav=1

Mental health outpatient attendances

178. Costs and activity should be reported for attendances and non face-to-face contacts.

179. Where consultants have a clinical caseload within a specialist team, the costs and activity should be reported against the specialist team currencies.

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

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

181. Primary consultations before the patient attends for a traditional first appointment should not be recorded as an attendance. Rather, the cost of such contacts should form part of the unit costs of contacts with service users once accepted for treatment by the relevant service.

182. Payments for domiciliary visits are now only made in limited circumstances, or to consultants who have chosen to retain the old consultant contract (Section 12(2) 2003[68]). Please contact costing@improvement.nhs.uk for guidance on this.

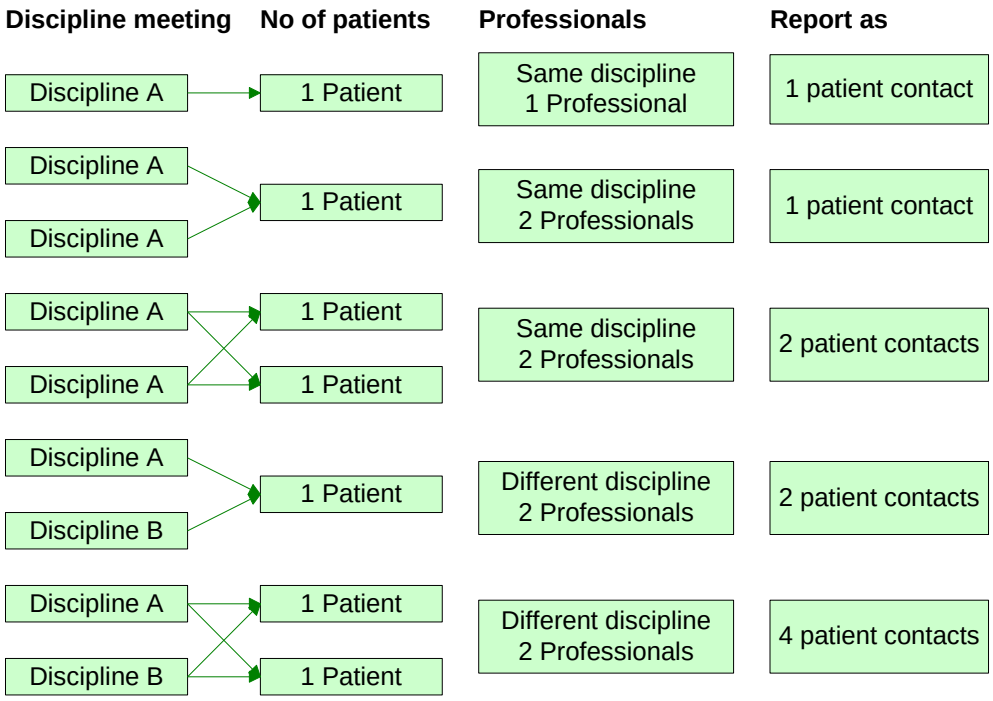
Community mental health teams

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

[68] http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/Consultant_Contract_V9_Revised_Terms_and_Conditions_300813_bt.pdf

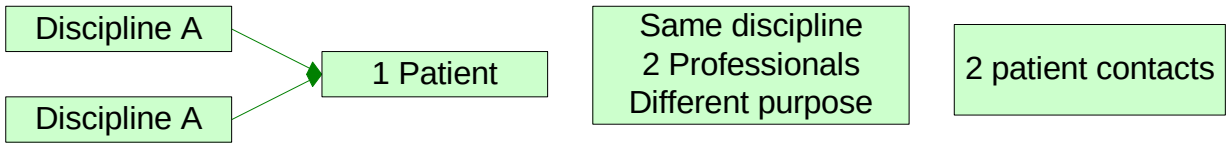
184. It is rare for patients to meet more than one discipline (ie qualified professional staff group within each CMHT) at a time. When this does occur, you should record the attendance as two separate contacts for NCC average cost collection purposes. Figure 1 describes this process.

Figure 1: Reporting patient contacts with multidisciplinary community mental health teams



185. The exception to this general principle is when two or more professionals from the same discipline meet a single patient at the same time but for a different purpose (Figure 2).

Figure 2: Reporting patient contacts with two or more professionals from the same discipline



Mental health specialist teams

186. Most cost and activity data for services undertaken by mental health specialist teams (MHSTs), using currencies based on the annual national survey of investment in adult mental health services,[69] should be included in the care clusters. Remaining costs and activity should be reported on a patient contacts basis for:

- A&E mental health liaison services
- psychiatric liaison: acute hospital/nursing homes
- forensic liaison services
- other psychiatric liaison services
- criminal justice liaison
- forensic community
- psychosexual services
- prison health
- other mental health specialist teams.

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

Adult forensic and secure mental health services

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

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

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

- clusters developed for working-age adults and older people (Table 9)
- the five pathways (Table 12).

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

Table 4: Five pathways

Number	Description
1	Treatment responsive
2	Treatment-resistant challenging behaviours
3	Treatment-resistant continuing forensic care
4	Prison transfer: personality disorder
5	Personality disorder co-morbid

191. NHS England and NHS Improvement have developed a cluster and pathway combination matrix, which creates the proposed currencies for submission of costs.

192. Templates have been designed to capture the data consistently for all APC security levels broken down into 18 currency groupings:

- one initial assessment currency (this relates to the period – normally 12 weeks – at the beginning of the patient's care when they are allocated a cluster and a pathway); costs should be submitted **per initial assessment**
- 16 dominant cluster and pathway combination currencies; costs should be submitted **per occupied bed day**
- one 'other' currency for those clusters and pathways which do not fit into the dominant 16 combination currencies.

193. See Annex 2 for more detail.

194. Since 1 April 2017, providers of these services have been required to collect and submit cluster–pathway data to MHSDS v4.0, which is held by NHS Digital as set out in contracts between NHS England Specialist Commissioning and providers.

Annex 1: Allocation of mental health services within NCC average costs

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

Service	Included in cluster cost collection	Included in non-cluster cost collection	Excluded from cost collection
Psychiatric liaison services including A&E liaison, acute hospital liaison, nursing home liaison, etc		Yes	
Adult specialist eating disorder services		Yes	
Autism and Asperger's syndrome		Yes	
CAMHS		Yes	
Drug and alcohol services		Yes	
Eating disorder services (children and adolescents)		Yes	
Forensic and secure mental health services: inpatients	Yes		
Forensic outpatients		Yes	
Gender identity disorder services		Yes	
Improving Access to Psychological Therapies (IAPT)	Yes		
Learning disability services in high dependency or high secure units		Yes	
Mental health services for deaf children and adolescents		Yes	
Mental health services for military veterans		Yes	
Mental health services provided under a GP contract		Yes	
Perinatal mental health services (mother and baby units)		Yes	
Primary diagnosis of drug or alcohol misuse		Yes	
Specialised addiction services		Yes	
Specialist mental health services for deaf adults		Yes	
Specialist psychological therapies (admitted patients and specialised outpatients)		Yes	

Service	Included in cluster cost collection	Included in non-cluster cost collection	Excluded from cost collection
Acquired brain injury			Yes
Learning disability services not provided in high dependency or high secure units			Yes
Neuropsychiatry			Yes

* These services are only included in clusters where NHS funded; otherwise they are excluded.

** Where the service is provided to a clustered user, the cost is included in the cluster. Where the service is provided to a non-clustered user, the cost is included in a non-cluster currency.

Annex 2: Data we will collect for the mental healthcare clusters

Field	Comments
Cluster costs (service code MHCC)	
Unit cost per day per cluster	Average/weighted cost per day per patient per cluster. This is a calculated field, equal to: (Unit cost per occupied bed day × Number of cluster days in admitted patient care) + (Unit cost per non-admitted cluster day × Number of cluster days in other settings) / Number of cluster days within the financial year
Number of cluster days within the financial year	Total number of patient days within each cluster within the financial year. This is a calculated field, equal to: Number of cluster days in admitted patient care + Number of cluster days in other settings
Memorandum information	
Unit cost per occupied bed day	This covers admitted patient care on an occupied bed-day basis covering ordinary elective and non-elective activity, including leave days. This is contrary to the guidance for non-cluster mental health activity, which states that the leave beds should be excluded to the extent that this ensures occupancies above 100% cannot be reported.
Number of cluster days in admitted patient care	
Unit cost per non-admitted cluster day	This is the cost per day based on the number of days between the start and finish (or year-end) of the cluster review periods, when the patient was not in admitted patient care. It is not the number of contacts. Refer to the note in the row above if there is an overlap of care.
Number of cluster days in other settings	

Field	Comments
Total number of completed cluster review periods	Total number of review periods in each cluster. If a patient has been allocated to a cluster more than once during the year, each separate time should be counted. A reassessment resulting in the patient remaining in the same cluster does result in a new review period. All review periods which are completed during the year should be counted. Include review periods that started in the previous year and were completed in the current year. Exclude review periods that started in the current year and will not be completed until next year.
Average review period (days)	Average length of a cluster review period. This is the average interval between review dates for each patient expressed in days. Only completed review periods should be included in the average calculation: part review periods at the beginning and end of the year should not be counted. Where there is an annual review period, record 365 here or actual length if available.
Initial assessments (service code MHCCIA)	
Unit cost per initial assessment	This covers the costs and activity associated with initial assessments of patients, which helps clinicians allocate them to clusters. Initial assessment and clustering of patients can require significant professional resource, and are therefore identified separately rather than included as a support cost for patients who are clustered.
Number of initial assessments	

Annex 3: Example cluster calculations

Error! Reference source not found.describes a patient who changes cluster. The patient is assessed and spends 28 days in cluster 14 at a cost of £10,000. They are then reviewed and reallocated to cluster 15, spending 20 days there at a cost of £8,000. They are re-reviewed and returned to cluster 14, and are reviewed at 28-day intervals. In total they spend 72 days until the end of the year in cluster 14 at a cost of £40,000. The 16 days to the year-end are not counted as a review period or in the average review calculation.

Table A3.1: Patient change of cluster

Cluster	Total cost	Number of cluster days within the costing period	Unit cost per day per cluster	Total number of complete review periods	Average completed review period (days)
14	£50,000	28 + (28 + 28 + 16[70])= 100	£500	3	28
15	£8,000	20	£400	1	20

Error! Reference source not found. describes a patient who is assessed multiple times in-year within a cluster. They are allocated to cluster 15 at a cost of £15,000. The first review after 28 days indicates they should remain in cluster 15, where they spend 26 further days at a cost of £15,000. They are re-reviewed and again stay in cluster 15, where they spend the remaining eight days until the end of the year at a cost of £1,000. There are two review periods, with an average review period of 27 days (26 + 28/2). The eight days to the year-end are ignored.

[70] 28 + 28 + 26 = 72.

Table A3.2: Multiple assessment of patient

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

Annex 4: Dominant pathway and cluster

Dominant pathway	Dominant cluster	Proposed code for each currency	Description
N/A	N/A	IASS	Initial assessment period (normally 12 weeks)
1	10	110	Treatment – shorter term – first episode in psychosis (medium/high risk)
1	11	111	Treatment – shorter term – recurrent psychosis (low symptoms, medium/high risk)
1	12	112	Treatment – shorter term – recurrent psychosis (high disability, medium/high risk)
2	11	211	Treatment – longer term – ongoing psychosis (low symptoms, low/medium risk)
2	12	212	Treatment – longer term – ongoing psychosis (high disability, low/medium risk)
2	13	213	Treatment – longer term – ongoing psychosis (high symptoms and disability, low/medium risk)
2	17	217	Treatment – longer term – psychosis and affective disorder (difficult to engage, low/medium risk)
3	11	311	Treatment – longer term – ongoing psychosis (low symptoms, medium/high risk)
3	12	312	Treatment – longer term – ongoing psychosis (high disability, medium/high risk)
3	13	313	Treatment – longer term – ongoing psychosis (high symptoms and disability, medium/high risk)
3	14	314	Treatment – longer term – psychotic crisis (medium/high risk)

Dominant pathway	Dominant cluster	Proposed code for each currency	Description
3	16	316	Treatment – longer term – dual diagnosis (medium/high risk)
3	17	317	Treatment – longer term – psychosis and affective disorder (difficult to engage, medium/high risk)
4	8b	48b	Personality disorder – non-psychotic (medium/high risk, prison transfer)
5	8	58	Personality disorder and psychosis (medium/high risk)
5	8b	58b	Personality disorder non-psychotic (medium/high risk)
N/A	N/A	OTH	Patients with a cluster and pathway combinations not covered

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