NHS

Approved Costing Guidance – Standards

Acute costing methods

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Contents

CM1: Medical staffing

Purpose: To allocate medical staff costs to the activities they deliver.

Objectives

1. To ensure all medical staffing costs are allocated in the correct proportion to the activities they deliver, using an appropriate cost allocation method.

2. To allocate the actual medical staffing costs to their named activity if available.

Scope

3. This standard applies to all medical staffing costs in the cost ledger.

Overview

4. Medical staff form a large proportion of your organisation's costs and are likely to deliver a significant proportion of patient-facing activities.

5. To ensure this activity is costed as accurately as possible, you should allocate the actual medical staff costs to their own named activity if available. Non-consultant medical staff costs should be allocated as for other staff groups to the correct resources and activities.[1]

6. For example, Ms Smith is a consultant ophthalmologist. Ms Smith's costs should be allocated to her activity using the prescribed cost allocation methods in Spreadsheet CP3.3.

7. If clinicians are to use patient-level costing effectively to improve services, they need to be confident their activity is costed appropriately. Allocating their

[1] If you do allocate non-consultant medical staff and other named healthcare professional costs directly to patients, this is a superior costing method. See superior method SCM7 in Spreadsheet CP3.5 for more information.

actual costs to the activity they have delivered, rather than an average cost, will increase their confidence in the cost data's accuracy.

8. To cost medical staff activities accurately you need to understand where medical staff work in your organisation, eg in emergency or pathology departments.

9. You also need to understand which of the activities delivered by medical staff are patient-facing and which are 'other' activities (the latter include research and development and education and training).

Approach

10. Review the prescribed list of activities in Spreadsheet CP3.2 and identify those your medical staff deliver.

11. Allocate all medical staffing costs using the following resource IDs:
    - SGR062 Consultant
    - SGR064 Consultant – anaesthetist
    - SGR063 Non-consultant medical staff
    - SGR065 Non consultant medical staff – anaesthetist.

12. Table CM1.1 is an excerpt[2] from Spreadsheet CP3.3 showing the resource and activity links to use for consultant and non-consultant medical staffing.

13. For each resource and activity combination there is a two-step prescribed allocation method in Spreadsheet CP3.3.

14. You will need to identify the quantum of medical staffing costs to allocate to each type of activity using a percentage split of medical staffing costs by activity type. You can find this out through discussions with medical staff, using job plans or other sensible means, such as theatre planning systems, outpatient clinic set-ups, live job diary recording or electronic clinical notes (see Figure CM1.1).

[2] Please note all excerpts in this standard are for illustrative purposes only. Spreadsheet CP3.3 gives a full list of resource and activity links.

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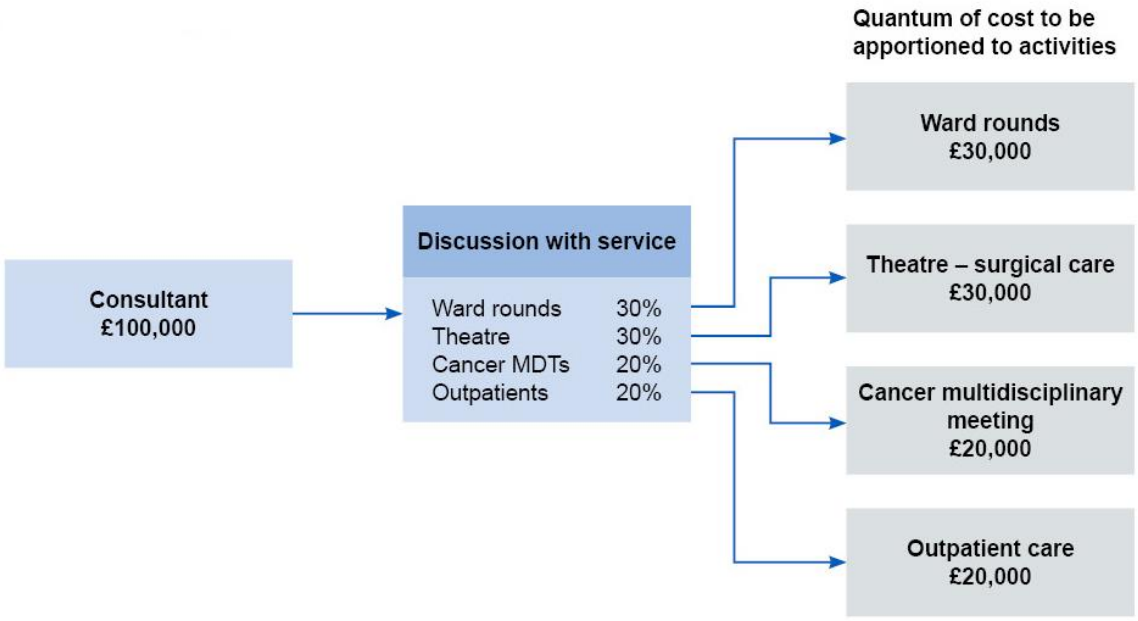
Table CM1.1: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for consultant and non-consultant medical staffing costs

	Activity									
Resource	**A&E – medical care**	**Adult critical care – medical care**	**Ward round**	**Research and development**	**Outpatient procedure**	**Endoscopy**	**Theatre – surgical care**	**Pain management care**	**Genetics testing**	**X-ray**
Consultant	£X	£X	£X	£X	£X				£X	£X
Consultant – anaesthetist			£X		£X	£X		£X		
Non-consultant medical staff							£X			
Non-consultant medical staff – anaesthetist					£X		£X			

Figure CM1.1: Identifying the correct quantum of cost to be apportioned to activities



15. Where your organisation records team working or locum staff as a 'generic' consultant, you will not be able to allocate actual staff costs for the named consultant. You will have to identify where the staff costs sit in the general ledger and map them to the appropriate activities on a relative weight value (RWV) basis.

16. Do not use consultant job plans as a basis to allocate other medical staffing costs, such as those for non-consultant medical staff or consultant nurses. Allocate those costs based on discussions with those staff groups and other information sources.

17. An example template for gathering this information is included in integrated costing assurance log (ICAL) worksheet 23: CM1 consultant % split.

18. For some consultant medical staff, the percentage split of consultant medical staffing costs by activity type may be divided further for specific groups of patients.

19. Do not apportion the same percentage split to all activity types unless evidence suggests that is appropriate. You must document the rationale for the percentage split you use in ICAL worksheet 24: CM1 consultant % reasoning.

20. The apportionment should take place in your costing system to give you the quantum of cost for each activity type.

21. Once the quantum of cost for each activity type has been calculated, the costs are allocated using the prescribed cost allocation methods in Spreadsheet CP3.3.

Ward rounds

22. Ward rounds are regular or planned consultant visits to the ward to review a range of patients. They can also involve nurses, non-consultant medical staff, therapists and other staff. (Note: where material, the costs of all these staff should be identified as part of the ward round activity.)

23. The activity ID: SLA098; Ward round should show the cost of the relevant resources for the staff attending the ward round.

24. If the clinical service deems all ward rounds to be identical, the split of activity to patient level can be based on number of patients alone. No further information is needed.

25. If any consultant medical staff in your organisation care for patients with different treatment function codes (TFCs), or other specific characteristics, and ward rounds vary in duration because of this, find out from discussions with medical staff what the average duration of a ward round is for the different patient groups.

26. Table CP3.4 in Standard CP3: Allocating costs to activities contains a template for a statistic allocation table for ward rounds. This allows you to develop RWVs for patient groups who require longer ward rounds, complex or weekend ward rounds.

27. Use this information as a RWV alongside length of stay to allocate ward round costs that better reflect the time medical staff spend with patients.

28. Consultant anaesthetists may also do pre-surgery ward rounds for patients due to go to theatre. Work with consultant anaesthetists to find out if they do pre-surgery ward rounds, which patients they visit and the average time they

spend with each patient. Use this information to develop a RWV to assign these patients an appropriate element of consultant anaesthetist costs.

Non-admitted patient care[3]

29. You need to understand which consultant medical staff are involved in multidisciplinary outpatient clinics to ensure they are all included in the costing of these clinics.

30. Consultant anaesthetists may be involved in or run pain management or critical care outpatient clinics. Work with consultant anaesthetists to find out if they are involved in outpatient care and if they perform any procedures. Use this information to develop a RWV to assign these patients an appropriate element of consultant anaesthetist costs for these activities.

Theatres

31. For information on medical staff in theatres, refer to Standard CM5: Theatres and special procedure suites.

Medical reviews

32. Where medical staff review patients managed under a different specialty from their own – for example, a cardiac patient with asthma is reviewed by a respiratory consultant, this contact should be costed and included in the final patient unit costs.

33. There are different ways to capture this information. Examples include:
    - record on the organisation's patient administration system (PAS)
    - record on clinical notes systems and extract electronically for PLICS
    - record separately for material amounts of reviews or where the clinical team are keen to know the time they spend on this work.[4]

34. These contacts can be reported in the supporting contacts feed[5] (feed 7). If this is the case, the prescribed matching rules for the supporting contacts feed

[3] See also Acute standard CM3: Non-admitted patient care for more information.
[4] Please note: we do not wish PLICS alone to increase the recording of this information, but if a clinical team needs this information, that is a strong reason to collect it. We do not expect a costing team to do the recording.
[5] This is a superior costing method.

in Spreadsheet CP4.1 will ensure the medical review is matched to the correct patient's episode, contact or attendance.

35. Medical reviews should be costed using activity ID: SLA099; Supporting contact.

Pain management

36. Consultant anaesthetists may be part of a peripatetic pain management team that provides pain management care to inpatients. This information should be recorded on the supporting contacts feed (feed 7) and the costs allocated using the two-step prescribed allocation method in Spreadsheet CP3.3.

Clinical support services

Pathology

37. Most pathology consultants specialise in a particular field, such as haematopathology or forensic pathology. They may conduct tests, examine biological samples and collaborate with other physicians to diagnose illnesses.

38. Use the table in Appendix 1 in Standard CP3: Allocating costs to activities to identify the consultant input to pathology tests and ensure the tests are allocated an appropriate proportion of consultant costs.

39. Consultant pathologists may be involved in more clinical activities than testing – for example, consultant microbiologists may be involved in delivering patient-facing infection control activities. Work with the department to ensure that consultant costs are allocated appropriately to all the activities its consultants undertake. To do this, you should customise your general ledger to cost ledger mapping (or general ledger to resource mapping) process, so the different types of service are identifiable.

40. As a superior method, you can add a RWV for acuity of tests to the consultant costs.

41. Use Spreadsheet CP3.3 to identify the pathology activities the consultant resource is linked to.

Diagnostic imaging

42. Radiologists specialise in diagnosing and treating disease and injury using medical imaging techniques such as X-rays, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET), fusion imaging and ultrasound. As some of these imaging techniques use radiation, adequate training in and understanding of radiation safety and protection is important.

43. Use the table in Appendix 2 in Standard CP3: Allocating costs to activities to identify the consultant input to diagnostic imaging tests and ensure the tests are allocated an appropriate proportion of consultant costs.

44. Consultant radiologists may be involved in more clinical activities than diagnostic imaging – for example, they may be involved in delivering interventional radiology. Work with the department to ensure that consultant costs are allocated appropriately to all the activities its consultants undertake. To do this, you should customise your general ledger to cost ledger mapping (or general ledger to resource mapping) process, so the different types of service are identifiable.

45. As a superior method, you can add a RWV for acuity of scans to the consultant costs.

46. Use Spreadsheet CP3.3 to identify the diagnostic imaging activities that the consultant resource is linked to.

Critical care

47. Critical care consultant (anaesthetist intensivist) medical staffing cost should be allocated across all patients based on the duration of their critical care stay. See Standard CM6: Critical care for more information, including how to treat medical staff involvement in critical care transport.

48. If the patient in critical care is visited by a consultant during a ward round, that ward round should be costed and included in the cost of the critical care stay.

Non-clinical activities

49. Education and training (E&T) activities should be costed in line with the E&T transitional method.

50. E&T activities should not be matched to patients but reported under the ‘education and training’ cost group.

51. Research and development (R&D) activities should be costed using your current methods and documented in ICAL worksheet 20: Research and development. Cost R&D using activity ID: SPA155; Research and development.

52. R&D activities should not be matched to patients but reported under the ‘research and development’ cost group.

53. Other non-clinical activities should be allocated to clinical activities using the actual cost of the clinical activity as a RWV.

CM3: Non-admitted patient care

Purpose: To ensure all types of non-admitted patient care (NAPC) activity are costed consistently.

Objectives

1. To cost non-admitted services to a service team session or clinic level, then to allocate to the patients attending that clinic or visited in the community on that day.

2. To cost all NAPC based on the staff present.

3. To allocate the cost to the patients, based on the duration of the contact.

4. To ensure all types of NAPC activity are costed correctly, including consultations, procedures and telemedicine.

Scope

5. This standard applies to all NAPC activity, including hospital (outpatient) clinic appointments, other clinical settings (outpatient appointments) and contacts in the patient's residence[6] (community care contacts).[7.]

6. This standard covers the NAPC feed (feed 3a), in accordance with Standard IR1: Collecting information for costing and Spreadsheet IR1.2. Please note the source data requirement for this feed is the Commissioning Data Set (CDS).

[6] Or other non-clinical location.
[7] Please note that integrated trusts will also need to refer to the Mental health and/or Community standard CM3: Non-admitted patient care as appropriate. In the acute sector, these home visits are sometimes called 'domiciliary visits'.

Overview

7. NAPC takes place in many different settings, including formal outpatient clinics held in hospitals or community settings, and the patient's residence. Some appointments are booked in advance; others are 'drop-in'.

8. See Standard IR1: Collecting information for costing, for detail on the source datasets. In summary, for all sectors the NAPC data used should be that which is submitted nationally to the:
   - Commissioning Data Set (CDS): the source for acute outpatient appointment data
   - Community Services Data Set (CSDS): the source for community care contact and community clinic data
   - Mental Health Services Data Set (MHSDS): the source for mental health outpatient appointment or mental health community care contact data
   - Improving Access to Psychological Therapies dataset (IAPT): the source for IAPT NAPC data.

9. NAPC activity should be costed based on which staff are in the clinics/ sessions[8] and how long their attendance is (in minutes).

10. Some outpatient procedures may require input from a healthcare professional who is not a normal member of the clinic staff – for example, minor surgery may require an anaesthetist or practitioner to be present. Their cost needs to be allocated to the relevant patient based on the duration of their attendance.

11. You must ensure the outpatient department costs – such as those for the varied care professionals, administration, support nursing, etc – are allocated to all patients in the department, using the appropriate cost allocation method.

12. Outpatient procedures or interventions may take place in the consultation room (clinic) or a specialist treatment room. You need to ensure the correct department costs and clinical non-pay items are allocated to the procedure (see Standard CM21: Clinical non-pay items for more information).

[8] This does not include staff present for education and training purposes.

13. Contacts and procedures may also take place outside the outpatient department, such as in a patient's residence. The cost of these, including travel costs, must also be allocated using the duration of the contact in minutes.

14. Information on most NAPC contacts will be recorded on a pro forma completed by clinical staff. The main 'procedures' performed during the contact will be recorded by procedure codes (hospital care). Clinical coders will apply these codes or agree a set template of codes with you for the NAPC contact.

15. Many procedures and care activities are carried out in NAPC, so the materiality principle applies when prioritising the time you give to these. We recommend that in the first instance you identify either the five most frequent or highest value (regularly performed) NAPC procedures or interventions for your organisation and work with the department to refine the cost allocation methods for these – for example, identifying if a particular consumable is used or an extra staff member is involved. You should use OPCS or SNOMED CT clinically coded information from the local data, where available.

16. Non face-to-face (also called 'telemedicine') contacts are increasing, and it is important to include them in costing.[9]

Approach

17. Obtain the patient-level information feeds for all NAPC activity as prescribed in Standard IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2.

18. Use the prescribed matching rules in Spreadsheet CP4.1 to ensure the auxiliary patient-level information feeds, such as medicines dispensed (feed 10), match to the correct NAPC contact.

[9] If this activity is not recorded in or not submitted to the national datasets, work with your informatics teams to progress this. The non face-to-face contacts may form a large part of 'hidden activity', as discussed in Standard IR1: Collecting information for costing. It is essential to include this activity as care models change, so the outcome benefits can be understood.

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19. For outpatient activity (as recorded on the CDS) use the following prescribed activities:
    - SLA135 Outpatient care
    - SLA136 Outpatient procedure
    - SLA151 Preoperative assessment
    - SLA149 Telemedicine contact (where calls to the patient are part of the clinic)
    - SPA152 DNA (for those costing did not attends (DNAs) for local business intelligence).

20. For other NAPC contacts, including community care contacts, use the following prescribed activities:
    - CMA302 Community care
    - SLA149 Telemedicine contact (where telephone calls are ad hoc)
    - MHA267 Other telemedicine contact (see definitions in the *Costing glossary* and below).

21. If more detail is required for activities in the community – for example, by specialist nurses – refer to the community costing methods standards.

22. For groups of patients, see Standard CM14: Group sessions.

23. Table CM3.1 is an excerpt[10] from Spreadsheet CP3.3 showing the resource and activity links to use for an NAPC attendance.

24. For each resource and activity combination there is a two-step prescribed allocation method in Spreadsheet CP3.3.

25. Other activities on the NAPC feed (feed 3a) will have been assigned their own prescribed activity. Review the list of activities in Spreadsheet CP3.2 and identify which may be included on your NAPC feed, to ensure you use the correct prescribed activity and do not incorrectly assign their costs to the prescribed activities ‘outpatient care’ or ‘outpatient procedure’.

[10] Please note all excerpts in this standard are for illustrative purposes only. Use Spreadsheet CP3.3 to ensure you are using all the correct resource and activity links.

Table CM3.1: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for NAPC costs

Resource	Activity		
	Other non face-to-face contact	Outpatient care	Outpatient procedure
Advanced nurse practitioner	£X	£X	
Midwife	£X		
Psychologist	£X		
Speech and language therapist	£X		
Dietitian		£X	
Healthcare assistant		£X	
Medical and surgical consumables		£X	£X
Consultant		£X	£X

26. These activities may include but are not limited to the list in Table CM3.2.

Table CM3.2: Other NAPC activities

Activity ID	Activity
MDA062	Audiology assessments
SLA142	Chemotherapy delivery
SLA132	Endoscopy
SLA143	Pain management care
CLA047	Sleep studies

Costing using the NAPC data feeds

27. The CDS requires all NAPC contacts to be recorded. However, the quality of the data in some areas is known to be variable. If fields required for PLICS are

not recorded fully on your NAPC feed (feed 3a), the information may be available from another system recording pro formas (one per patient) or summary sheets completed by clinical staff.[11] You should use this information to guide discussions with clinical and service leads and enable you to enter non-CDS patient-level data into your NAPC feed. You may need to create proxy records for services that do not keep a record of patient contacts; see Standard IR2: Managing information for costing for more details.

28. To allocate the cost using duration of the attendance or contact, use the following data fields in Spreadsheet IR1.2:
    - CDS: field 'appointment duration'
    - CSDS: field 'clinical contact duration of care activity'
    - MHSDS: field 'clinical contact duration of care contact'
    - IAPT dataset: this does not have a field for duration of contact; you need to calculate the duration locally and enter it into the 'duration of contact' field in the IAPT feed (feed 16).

29. If your organisation does not record the duration of attendance in minutes for a particular service, work with your services and informatics teams to develop this information feed. While waiting for this information to become available and including it in your NAPC feed (feed 3a), continue to use your current method for costing outpatient activity and record this in ICAL worksheet 14: Local costing methods.

30. To help you cost NAPC, column D in the NAPC feed (feed 3a) in Spreadsheet IR1.2 contains the fields for each attendance/contact, as shown in Table CM3.3.[12]

31. The CDS contains the HRG field to identify multiprofessional and multidisciplinary activity separately from single professional activity, but it does not identify who was present. If the different staff types are considered material, you will need to collect information about who was present at the attendance to ensure the correct costs are allocated to the correct patient.

[11] See also Standard IR1: Collecting information for costing for how to work with missing data or poor data quality.
[12] For the mental health and community sectors, refer to the relevant feed in Spreadsheet IR1.2 and the Mental health or Community standard CM3: Non-admitted patient care.

32. Use this information to build relative weight values to allocate the appropriate staff costs to contacts; see Spreadsheet IR1.2.

Table CM3.3: Excerpt from Spreadsheet IR1.2 showing fields in the NAPC feed (feed 3) for costing types of NAPC contacts

Feed name	Field name	Field description
NAPC	Consultant-led or non consultant-led	Is the lead healthcare professional a consultant? Yes or No
NAPC	Healthcare professional code	Derived from either the General Medical Council (GMC) reference number for general medical practitioners, or the General Dental Council registration number for general dental practitioners (where the dentist does not have a GMC reference number). Where the consultant is not the responsible professional, use the local code for the responsible professional.
NAPC	Clinic code	Clinic or facility identifier.
NAPC	Consultation medium used	Identifies the communication mechanism used to relay information between the **care professional** and the **person** who is the subject of the consultation, during a **care activity**. The telephone or telemedicine consultation should directly support diagnosis and care planning and must replace a face-to-face clinic attendance. A record of the telephone or telemedicine consultation must be retained in the **patient's** record. Telephone contacts solely for informing **patients** of results are excluded.
NAPC	Multiprofessional flag	Flag for multiprofessional clinics.
NAPC	Multidisciplinary flag	Flag for multidisciplinary clinics.

33. Be aware that, in the patient-level information, a clinic may be assigned to the consultant with overall responsibility for it: this consultant may not necessarily be present in the clinic.

Costing the individual outpatient attendances and procedures

34. The total cost for the clinic is allocated to all patients seen in the clinic, based on the duration of their attendance. The field for the appointment duration in hours and minutes is included in column D in the NAPC feed (feed 3a) in Spreadsheet IR1.2.

35. Some NAPC contacts may require input from a healthcare professional who is not a member of the normal clinic staff. Their cost needs to be included for the relevant patient, based on the duration of their attendance.

36. You should pay particular attention to the consumables used during outpatient procedures.

37. Table CM3.4 is an excerpt[13] from Spreadsheet CP3.3 showing the resource and activity links to use for a multidisciplinary NAPC attendance

38. For each resource and activity combination there is a two-step prescribed allocation method in Spreadsheet CP3.3.

Table CM3.4: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for multidisciplinary NAPC attendance costs

Resource	Activity				
	Outpatient care	Interpreting – language	Outpatient procedure	Ward care	Supporting contact
Consultant	£X				
Non-consultant medical staff			£X		
Specialist nurse			£X		£X
Healthcare assistant	£X		£X	£X	
Dietitian	£X				£X
Psychologist	£X				£X
Medical and surgical consumables	£X		£X	£X	

[13] Please note all excerpts in this standard are for illustrative purposes only. Use Spreadsheet CP3.3 to ensure you are using all the correct resource and activity links.

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Resource	Activity				
	Outpatient care	Interpreting – language	Outpatient procedure	Ward care	Supporting contact
Interpreters		£X			£X
Patient specific consumables			£X	£X	

Ward attenders

39. These are patients attending a ward for a NAPC contact. They are usually seen by non-medical staff, but some may see a doctor. The ward attendance will be recorded on the NAPC feed (feed 3a), but the cost will come from a ward rather than an outpatient department. Some of the information used for costing these attendances will be found on the ward stay feed (feed 4).

40. The ward stay element of the ward attendance should be costed using the cost allocation methods in Spreadsheet CP3.3 and using activity ID: SLA097; Ward care.

41. You will need to identify any care professionals additional to the ward staff who are involved in the ward attendance. They should be recorded on the supporting contacts feed (feed 7)[14] and costed using activity ID: SLA099; Supporting contact.

42. You will need to identify any specific patient consumables used during the ward attendance using resource ID: MDR052; Patient-specific consumables (see also Standard CM21: Clinical non-pay items).

43. The prescribed matching rules in Spreadsheet CP4.1 have a matching option against the NAPC feed (feed 3a), so if the ward stay costs are purely from the ward stay feed (feed 4) they can be matched to the ward attendance on the NAPC feed.

44. Use the resource and activity matrix in Table CM3.4 for a ward attendance.

[14] This is a superior costing method.

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Day care

45. Day care is where a group of non-admitted patients benefit from care services in a group setting – usually over a few hours. A range of care professionals may provide care over the period of attendance. The activity may be recorded as NAPC or it may be on a standalone local system.

46. As with ward attenders, the staff involved are most likely to be nurses/therapists but in some areas there can be medical input. The model of care may be termed 'social' or 'medical' depending on its clinical content. There are separate cost centres in the cost ledger should you need to keep the two types of model separate.[15] See Standard CM14: Group sessions for more information.

47. You should use the activity ID: MHA262; Day care.

Non face-to-face (telemedicine) consultations

48. Non face-to-face contacts are a vital part of clinical care for many patients.

49. Most of these contacts will be by telephone, but video messaging is increasingly being used. For costing purposes, these are both defined as 'telemedicine'. Use activity ID: SLA149; Telemedicine consultation (telephone and video consultation).

50. Other non face-to-face contacts include text conversations, email, patient-online schemes and patient letter review.[16] These need to be separated from those made via telemedicine, as the duration of 'patient contact' will be different. Use activity ID: SLA102; Other non face-to-face contact.

51. Clinical calls are all countable within the NAPC dataset using the 'consultation medium used' field. See Table CM3.5 showing the NHS Data Dictionary codes for this field.

[15] Note: Day care – even surgical or medical day care – is different from 'day hospital', which is an admitted patient care (APC) unit.

[16] Note: As there is no current guidance for these communication methods in the NHS Data Dictionary, we apply the same guidance as for telephone contacts. If you include these in your PLICS, we recommend you include your local policy on what constitutes the currency in ICAL worksheet 1.3: Local activity definitions.

Table CM3.5: NHS Data Dictionary codes for consultation media

Code	Method of communication
01	Face-to-face communication
02	Telephone
03	Telemedicine web camera
04	Talk type for a person unable to speak
05	Email
06	Short message service (SMS) – text messaging
98	Other

52. Telemedicine and other non face-to-face contacts are often 'hidden activity' (see Standard IR1: Collecting information for costing). Therefore, you may need to identify where there are gaps in your NAPC data.

53. Where there is a clinical element to the contact – for example, to support diagnosis, treatment and care planning – the contact is countable within the NAPC dataset.[17] These contacts should be counted and costed as they often replace the need for a face-to-face contact and prevent condition escalation, making an effective contribution to agreed pathways. Non face-to-face contacts simply to make bookings or pass on results without advice and guidance are not countable.

54. If services record their non-face-to-face calls on a separate database to the patient administration system (PAS), you need a patient-level feed that includes all important identifiable information.

55. You need to find out if the time recorded for a non face-to-face consultation is the actual call duration or if it includes preparation and write-up time. **Only the duration of the phone call should be costed** for consistency with the costing of other NAPC contacts, with the additional cost being absorbed. Preparation time is treated as administration time, not contact time.

[17] Detailed definitions and recording protocols for text and email are not given yet in the NHS Data Dictionary.

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56. The ‘clinical contact duration of care contact’ field for the appointment duration in hours and minutes is included in column D in the NAPC feed (feed 3a) in Spreadsheet IR1.2.

57. Only one staff member is likely to be involved in telemedicine and other non face-to-face contacts, but multiprofessional contact is possible. The appropriate resources should be attached to the activity accordingly.

58. For costing, telemedicine and other non face-to-face contacts should be treated in the same way as face-to-face contacts.

Group sessions

59. These occur when several patients have a contact with a single or multiple care professionals at the same time.

60. Group sessions are identified by the ‘group therapy indicator’ field in the NAPC feed (feed 3a) (see Spreadsheet IR1.2).

61. The costing method for these is detailed in Standard CM14: Group sessions.

Separate datasets

62. The information feeds for some discrete services in the organisation may be separate from those showing contacts in the CDS. These should be costed in the same way as other NAPC contacts – that is, using the duration of the contact – where sufficient information is available. Examples include:
    - sexual health (see Community standard CM16: Sexual health services)
    - dentistry (see Community standard CM17: Dental services)
    - assisted reproduction
    - learning disabilities
    - addiction services, including drug and alcohol
    - perinatal mental health services
    - mental health liaison.

63. These datasets, where available, should be brought into the costing system as required by your organisation in accordance with Standard IR1: Collecting

information for costing, and the relevant costing method used for the detail of the costing process.

64. The costing of some mental health services in acute care settings requires additional guidance.

65. **Mental health liaison service:** Patients reporting mental health illness in an acute care setting may require assessment and/or treatment for their mental health condition as well as their physical condition. Mental health liaison teams work in acute providers; usually in emergency departments but they can work in other areas such as outpatient clinics, emergency wards or elderly care wards supporting patients with dementia.

66. The cost of these services will be recorded in the:
    - mental health organisation's ledger or
    - acute provider's ledger.

67. The costing of treatment will depend on the how the service is treated financially; see Standard CM8: Clinical and commercial services supplied or received for more details.

68. For either type of organisation, if activity information is available, it may be brought into the NAPC feed (feed 3a) and costed at patient level. However, this should not be submitted as part of the outpatient activity collection but used for business intelligence only.

69. If this activity information is not available, treat this as a resource with no patient-level activity and enter it in the reconciliation under 'other activities'.

NAPC DNAs – for guidance only

70. We do not prescribe how to cost DNAs in this version of the standards or the cost collection, but if required for local purposes, our recommended approach is available to download from the Open Learning Platform (OLP).[18]

[18] https://www.openlearning.com/nhs/courses/costing-improvement/HomePage/

CM4: Emergency department attendances (including A&E, minor injury units and walk-in centres)

Purpose: To ensure emergency department (ED) attendances are costed in a consistent way.

Objective

1. To ensure all ED attendances are costed according to the treatment procedures the patient receives.

Scope

2. This standard covers ED attendances reported under treatment function code (TFC) 180 as defined in the NHS Data Dictionary.[19] Attendances may be at adult, paediatric and mixed EDs, minor injury units (MIU) and walk-in centres (WIC).

3. This standard also covers any ED attendances recorded in the Emergency Care Data Set (ECDS).[20]

4. EDs may carry out several types of activity that are all reported under TFC 180. Any inpatient episodes and outpatient attendances reported under TFC

[19] https://www.datadictionary.nhs.uk/data_dictionary/attributes/t/tran/treatment_function_code_de.asp?shownav=1?query=%22treatment+function+code%22&rank=100&shownav=1

[20] The ECDS is the national dataset for urgent and emergency care. It replaced the Accident & Emergency Commissioning Data Set (CDS type 010).

180 should be costed using the costing process standards and Acute standard CM3: Non-admitted patient care.

5. All ED attendances within the costing period, including all patients discharged in the costing period and patients still in bed at midnight on the last day of the costing period.

Overview

6. We recognise that the time a patient spends in an ED from arrival to departure is not an appropriate relative weight value for allocating their costs, as someone with a relatively minor injury is likely to spend a disproportionate time in the department waiting to be seen.

7. **You should cost ED attendances by allocating costs weighted by the treatment procedures the patient receives.**[21]

Approach

8. Obtain the urgent care (A&E/MIU) feed (feed 2) [22] for all A&E and MIU attendances as described in Standard IR1: Collecting information for costing and in Spreadsheet IR1.2.

9. Use the prescribed matching rules in Spreadsheet CP4.1 to ensure the auxiliary patient-level feeds, such as diagnostics, match to the correct ED attendance.

10. You must understand all the activities your A&E, MIU and WIC deliver to ensure the correct costing method is applied.

11. Get this understanding through discussion with service managers and clinical leads covering the different activities. For example, consultant A works:

    - 50% of their time in A&E, so 50% of their costs should be allocated to activities on the urgent care (A&E/MIU) feed (feed 2)

[21] A new A&E Commissioning Dataset using SNOMED codes was introduced from October 2017.
[22] Column D in Spreadsheet IR1.2 gives the information requirements for ED attendances.

- 50% of their time on A&E wards, so 50% of their costs should be allocated to activities on the admitted patient care (APC) feed (feed 1a).

12. Use the following prescribed activities:
    - SLA119 A&E – advanced nurse practitioner (ANP) care
    - SLA120 A&E – department care
    - SLA121 A&E – medical care
    - SLA124 Minor injuries unit/walk in centre – department care
    - SLA125 Minor injuries unit/walk in centre – medical care.

13. Table CM4.1 is an excerpt[23] from Spreadsheet CP3.3 showing the resource and activity links to use for ED attendances.

14. For each resource and activity combination there is a two-step prescribed allocation method in Spreadsheet CP3.3.

Table CM4.1: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for ED attendance costs

Resource	Activity					
	A&E – advanced nurse practitioner care	A&E – department care	A&E – medical care	MIU/WIC – department care	MIU/WIC – medical care	Haematology testing
Advanced nurse practitioner	£X					
Healthcare assistant		£X		£X		
Medical and surgical consumables	£X	£X	£X	£X	£X	£X
Medical and surgical equipment and maintenance		£X	£X	£X	£X	£X

[23] Please note all excerpts in this standard are for illustrative purposes only. Use Spreadsheet CP3.3 to ensure you are using all the correct resource and activity links.

Acute costing methods

Resource	Activity					
	A&E – advanced nurse practitioner care	A&E – department care	A&E – medical care	MIU/WIC – department care	MIU/WIC – medical care	Haematology testing
Nurse		£X		£X		
Patient-specific consumables	£X	£X			£X	
Consultant			£X		£X	£X
Non-consultant medical staff			£X		£X	£X

Costing using treatment procedures information

15. Use the 'treatment' field in the urgent care (A&E/MIU) feed (feed 2) in column D in Spreadsheet IR1.2.

16. Set up relative weight values for each treatment procedure type to use in the costing process. You need to develop these with the ED clinical and service leads. Table CM4.2 shows how the statistic allocation table could look.

Table CM4.2: Example of a statistic allocation table per treatment procedure[24]

Treatment procedure code	Procedure	Nurse (min)	HCA (min)	Consultant (min)	Non-consultant medical staff (min)	Patient-specific consumables (£)
8	Removal of foreign body	60	30	10	20	10
11	Dressing minor wound/burn/eye	60	30	5	10	20

[24] All values are for illustrative purposes only. Your data feed may include SNOMED treatment procedure codes, not those shown in Table CM4.2.

Treatment procedure code	Procedure	Nurse (min)	HCA (min)	Consultant (min)	Non-consultant medical staff (min)	Patient-specific consumables (£)
12	Dressing minor wound/burn/eye	60	30	5	10	20
51	Removal of plaster of Paris	60	30	10	20	0

17. Where there are no treatment procedure codes in the data to be used for costing, use the duration of the attendance as the cost driver.

Major trauma patients

18. **Treat major trauma patients in the same way as above;** they are allocated their own costs depending on the treatment procedures they receive.

19. Be aware that major trauma patients may have a separate funding source, so they need to be flagged in the urgent care (A&E/MIU) feed (feed 2) to allow you to correctly allocate the income received for internal reporting and business intelligence purposes.

20. Use the major trauma flag in column D in the urgent care (A&E/MIU) feed (feed 2) in Spreadsheet IR1.2 to identify these patients.

21. Major trauma patients may have critical care input while in ED. Standard CM6: Critical care provides guidance on how to identify these costs. **These costs should be included in the costs of the ED attendance.**

CM9: Clinical MDT meetings

Purpose: To ensure clinical multidisciplinary team (MDT) meetings are costed consistently.

Objective

1. To cost all clinical MDT meetings hosted by the organisation that are not recorded elsewhere, eg in the non-admitted patient care (NAPC) feed (feed 3a).

Scope

2. This standard applies to all MDT meetings hosted by your organisation, whether held locally or nationally, at which the treatment of patients is reviewed.

3. Clinical MDTs are reviews by staff of available treatment options and individual responses. Patients do not attend these meetings. Please note this standard includes both clinical (non-cancer) and cancer-specific MDT meetings.

4. This is because all MDT meetings which incur a material cost should be costed and reported locally for business intelligence.

5. This standard also applies where your organisation does not host the MDT but your staff spend material amounts of time attending them.

Overview

6. You need to know the types of clinical MDT meetings hosted by your organisation, in particular understanding which are for cancer and which are not,[25] eg breast, retinoblastoma, leukaemia, specialist palliative care.

7. Clinical MDT meeting costs are not allocated to individual patients but are reported at specialty level. They are kept separately from other costs as they are a significant cost and involve patients from different organisations being discussed by clinical experts.

8. Clinical MDT meeting costs need to be reported locally alongside any corresponding income for business intelligence at service level.

9. Clinical MDT meetings should be reported under the 'own patient activities' cost group.[26]

Approach

10. Obtain the clinical MDT meetings feed (feed 14) from your organisation's MDT meeting information database as prescribed by Standard IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2.

11. The feed contains the number of times each MDT meeting is held during the calendar month or year.

12. Use activity ID: SLA127; Cancer multidisciplinary meeting and activity ID: SLA128; Other multidisciplinary meeting.

13. Table CM9.1 is an excerpt[27] from Spreadsheet CP3.3 showing the resource and activity links to use for MDT meetings.

14. This feed is classified as a standalone feed so prescribed matching rules are **not** provided in columns H to O in Spreadsheet CP4.1.

[25] Please refer to the national cost collection guidance for more information on cancer MDTs in the national cost collection.
[26] See Standard CP5: Reconciliation for more information on cost groups.
[27] Please note all excerpts in this standard are for illustrative purposes only. Use Spreadsheet CP3.3 to ensure you are using all the correct resource and activity links.

Table CM9.1: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for MDT meeting costs

Resource	Activity	
	Cancer multidisciplinary meeting	Other multidisciplinary meeting
Advanced nurse practitioner	£X	
Clinical scientist	£X	£X
Consultant	£X	£X
Dietitian	£X	£X
Non-consultant medical staff	£X	
Occupational therapist	£X	
Physiotherapist	£X	
Psychologist	£X	
Radiographer	£X	
Specialist nurse	£X	
Speech and language therapist	£X	
Technician	£X	£X
Therapist	£X	£X
Cancer multidisciplinary meeting co-ordinator	£X	

15. Set up relative weight values to calculate an average cost for the MDT meeting to be used in the costing process.

16. Use the costing template in integrated costing assurance log (ICAL) worksheet 27: Clinical MDT meetings to identify the information you need to set up the statistic allocation table, including:

    - meeting members, including whether they are internal or external staff and the department they belong to
    - length of the meeting

- number of meetings attended by each member over the last year to calculate the average number of each type of meeting each member attends
- preparation time for an MDT meeting, particularly the time staff spend reviewing diagnostic test results.

17. See column A in ICAL worksheet 27: Clinical MDT meetings for an example of the potential attendees at a clinical MDT meeting whose input may need to be costed.

18. Resource ID: SLR091; Cancer MDT meeting co-ordinators have been classified as a type 2 support resource and are linked to activity ID: SLA127; Cancer MDT meeting in Spreadsheet CP3.4.

19. Overheads (type 1 support costs, such as room use, catering, heating, lighting and printing, need to be allocated appropriately.

Attendance at MDT meetings as subject matter experts

20. You will need to identify the frequency of these meetings and who from your organisation attends.

21. Use activity ID: SLA127; Cancer MDT meeting or activity ID: SLA128; Other MDT meeting.

22. Follow the costing method for hosted clinical MDT meetings.

23. You will need to find out whether staff attend because your organisation's patients are discussed at these national meetings or as 'subject matter experts'.

24. If your organisation's patients are discussed, report the activity under the 'own-patient activity' cost group. If the attendees are 'subject matter experts', report this activity under the 'other activities' cost group. See Standard CP5: Reconciliation for further information on cost groups.

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