# NHS

## Approved Costing Guidance – Standards

# Community costing methods

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**NHS England and NHS Improvement**

# Contents

# CM3: Non-admitted patient care

Purpose: To ensure all types of non-admitted patient care (NAPC)[1] activity are costed consistently.

## Objectives

1.   To cost non-admitted services to a service team session or clinic level, then to allocate them 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 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 (community clinic attendances) and contacts in the patient's residence[2] (community care contacts).[3]

6.   This standard covers the NAPC – community feed (feed 3c) for community care contacts and community clinic attendances and NAPC – community feed (feed 3a) for outpatient clinic attendances, in accordance with Standard IR1:

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[1] NAPC is used throughout this standard to cover all forms of non-admitted patient contacts.
[2] Or other non-clinical location.
[3] Please note that integrated trusts will also need to refer to Acute and or Mental health standard CM3: Non-admitted patient care as appropriate.

Collecting information for costing and Spreadsheet IR1.2. Please note the source data requirements for these feeds listed below.

# Overview

7.    NAPC takes place in many different settings, including formal outpatient clinics held in hospital or community settings, and the patient's residence. Some appointments are booked in advance; other services 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 and community care contact data
- Improved Access to Psychological Therapies Data Set (IAPT): the source for IAPT NAPC data.

9.    NAPC activity should be costed based on which staff are in the clinics/ sessions[4] and how long the attendance is (in minutes).

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

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

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

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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)

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 in the contact will be recorded by procedure codes (hospital care). Clinical coders will apply these or they will agree a set template of codes with you for the NAPC record.
    - Other community care activities will be recorded by SNOMED CT codes (community care). These will be applied by the healthcare professional.[5]

15. If you think the quality of the electronic data is not good enough, you should obtain a copy of a blank pro forma[6] and use it to guide discussions with clinical and service leads about what the most commonly performed procedures/ activities are, and what clinical non-pay items[7] and staff are involved in delivering the contacts.

16. 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.

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[5] SNOMED-CT is mandated for NHS providers from April 2020.
[6] Where this is electronic, you could obtain a print out or screen shot.
[7] See also Standard CM21: Clinical non-pay items.

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17. Non face-to-face (also called 'telemedicine') contacts are increasing and it is important to include them in costing.[8]

# Approach

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

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

20. For **community care contacts** (as recorded on the CSDS), use the following prescribed activities:

   - CMA302  Community care – for general contacts, eg district nursing
   - CMA300  Health visiting contact
   - CMA301  School nursing contact
   - CMA309  Other rehabilitation care
   - CMA310  Stroke rehabilitation care
   - CMA311  Musculoskeletal care
   - CMA313  Pregnancy advisory/family planning care
   - CMA314  Rapid response assessment/care
   - CMA315  Long-term conditions care
   - CMA316  Rheumatology care
   - CMA317  Respiratory care
   - CMA318  Intravenous therapy care
   - CMA319  Children's community care
   - CMA320  Tuberculosis care
   - CMA321  Cancer-related care
   - CMA322  Cardiac care
   - CMA323  Continence advisory care

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[8] 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. The benefits from changing care models can only be understood if this activity is included.

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- CMA324     Diabetic care
- CMA325     Enteral feeding care
- CMA326     Haemophilia care
- CMA328     Palliative/respite care
- CMA329     Neurological care
- CMA330     Stoma care
- CMA331     Tissue viability care
- CMA332     Transplantation patients care
- SLA149     Telemedicine contact (where telephone calls are ad hoc)
- MHA267     Other telemedicine contact (see definitions in the *Costing glossary* and below).

21. In compiling this list of activities we have been mindful of the feedback that a single community care activity does not provide sufficient detail for community provider costing.

22. For **clinic** attendances,[9] use the following prescribed activities:

- CMA302     Community care (where a clinic is recorded on the CSDS, not the CDS)
- SLA135     Outpatient care (where recorded on the CDS)
- SLA136     Outpatient procedure
- SLA151     Preoperative assessment
- CMA333     Treatment room care
- 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).

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

[9] See the *Costing glossary* for definition of clinic attendances.

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

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

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

| Resource | Activity | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| | Health visiting contact | Immunisation | Outpatient care | Cancer related care | Continence advisory care | Community care |
| Health visitor | £X | | | | | |
| School nurse | | £X | | | | |
| Healthcare assistant | | | £X | | | |
| Specialist nurse | | | | £X | | |
| Community nurse | | | | | £X | £X |

26. Other activities on the NAPC – community feed (feed 3c)[11] will have been assigned their own prescribed activity. Review the list of activities in Spreadsheet CP3.2 and identify which are included on your NAPC feed(s), to ensure you use the correct prescribed activity and do not incorrectly assign their costs to the prescribed activities 'outpatient care' or 'outpatient procedure'.

27. These other activities may include but are not limited to those listed in Table CM3.2.

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

[11] And NAPC – community feed (feed 3a) for acute outpatient contacts if relevant.

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**Table CM3.2: Other NAPC activities**

| Activity ID | Activity |
|-------------|----------|
| MDA062 | Audiology assessments |
| SLA132 | Endoscopy |
| CMA303 | Issuing of equipment |

## Costing using the NAPC data feeds[12]

28. The costing standards have integrated basic processes for all NAPC contacts, but some elements differ between sectors, as described below.

29. The NHS requires all community care contacts to be recorded in the CSDS, whichever sector the trust mainly operates in.

30. However, we know that some organisations have still to achieve this and that data quality in some areas is variable. If fields required for the PLICS are not recorded fully on your NAPC – community feed (feed 3c), the information may be available from another system, recording pro formas (one per patient) or summary sheets completed by clinical staff.[13] You should use this information to guide discussions with clinical and service leads and progress the submission of community data to the CSDS. This is so the recorded data can be matched to the CSDS.

31. To allocate the cost using duration of attendance or contact, use the following data fields as 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 on the IAPT feed (feed 16).

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[12] Including multidisciplinary clinics.
[13] See also Standard IR1: Collecting information for costing for how to work with missing or poor quality data.

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32. 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 – community feed (feed 3c), continue to use your current method for costing outpatient activity and record this in integrated costing assurance log (ICAL) worksheet 14: Local costing methods.

33. To help you cost NAPC, column D in the NAPC – community feed (feed 3c) in Spreadsheet IR1.2 contains the fields for each attendance/contact, as shown in Table CM3.3.[14]

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

| Feed name | Field name | Field description |
|---|---|---|
| NAPC | Care professional local identifier | A unique local 'care professional identifier' within a healthcare provider that may be assigned automatically. |
| 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**.<br><br>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.<br><br>Telephone contacts solely to inform **patients** of results are excluded. |
| NAPC | Multiprofessional contact | Used to identify where a multiple staff resource is used. This is not currently available on the CSDS but is a requirement for costing. |

34. The CSDS does not currently contain suitable fields to identify multiprofessional and multidisciplinary activity separately from single

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[14] For the acute and mental health sectors, please refer to the relevant feed in Spreadsheet IR1.2 and the Acute or Community standard CM3: Non-admitted patient care.

professional activity.[15] You will need to collect additional information about who was present in the clinic/contact to ensure the correct costs are allocated, and build this into your NAPC – community feed (feed 3c). This is key information for costing NAPC contacts correctly.

35. Use this information to build relative weight values to allocate the appropriate staff costs to contacts;[16] see Spreadsheet IR1.2.

36. Be aware that, in the patient-level information, a clinic may be assigned to the care professional with overall responsibility for it: that care professional is not necessarily present in the clinic.

## Medical and surgical consumables and equipment

37. We are advised that the unit cost of the consumables used in many NAPC contacts in community services are negligible. But if you find these costs are material, per patient or in total, please refer to Standard CM21: Clinical non-pay items. You should pay particular attention to the consumables used for procedures performed in clinical areas.

## Ward attenders

38. These are patients attending a ward for an 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 – community feed (feed 3a) or 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).

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

40. 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

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[15] We are working with NHS Digital to develop the CSDS to allow fields to be added – the standard and feeds will be updated when these fields are included in the CSDS..

[16] We acknowledge this information is currently not collected widely.

supporting contacts feed[17] (feed 7) and costed using activity ID: SLA099; Supporting contact.

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

42. The prescribed matching rules in Spreadsheet CP4.1 have a matching option against the NAPC – community feed (feed 3c); 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 – community feed (feed 3c) or NAPC feed (feed 3a).

## Day care

43. 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.

44. 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.[18] See Standard CM14: Group sessions for more information.

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

## Non face-to-face (telemedicine) consultations

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

47. Most of these contacts will be by telephone, but video messaging is increasingly being used. For costing purposes, both are defined as

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[17] This feed is a superior costing method.

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

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'telemedicine'. Use activity ID: SLA149; Telemedicine consultation (telephone and video consultation).

48. Other non face-to-face contacts include text conversations, email, patient-online schemes and patient letter review.[19] These need to be separated from those made by telemedicine, as the duration of 'patient contact' will be different. Use activity ID: SLA102; Other non face-to-face contact.

49. Clinical calls are all countable within the NAPC dataset using the 'consultation medium used' field. See Table CM3.4 showing the NHS Data Dictionary codes for this field.

**Table CM3.4: NHS Data Dictionary codes for different 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 |

50. 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.

51. 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.[20] These contacts should be counted and costed as they often replace the need for a face-to-face contact and prevent condition escalation,

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[19] 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.

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

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.

52. 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.

53. 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.

54. The 'clinical contact duration of care contact' field for the appointment duration in hours and minutes is included in column D in the NAPC – community feed (feed 3c) or NAPC feed (feed 3a) in Spreadsheet IR1.2.

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

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

## Group sessions

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

58. Group sessions are identified by the 'group therapy indicator' field in the NAPC – community feed (feed 3c) (see Spreadsheet IR1.2).

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

## Separate datasets

60. The information feeds for some discrete services in the organisation may be separate from those showing contacts in the CSDS. These should be costed

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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.

61. These datasets, where available, should be brought into the costing system as required for your organisation, in accordance with Standard IR1: Collecting information for costing, and the relevant costing method used for the detail of the costing process.

## NAPC DNAs – for guidance only

62. 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).[21]

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

# CM13: Admitted patient care

> Purpose: To ensure admitted patient care (APC) is costed consistently.

## Objective

1. To ensure costs are correctly allocated to episodes[22] of APC.

## Scope

2. This standard applies to all community APC.

## Overview

3. Inpatient community wards provide a safe and therapeutic environment for patients with a range of long-term conditions who are stepping down from care in the acute setting and being prepared for transfer to rehabilitation, home or to residential care. Some wards will be secure to ensure the safety of the individual and others – for example, a geriatric ward for patients with dementia. The type of wards established will depend on the level of care needed. Rehabilitation is promoted from admission on all wards, but some wards will be dedicated to rehabilitation.

4. As part of a longer care pathway, patients may spend time in an APC setting. The periods when patients are receiving APC are referred to as APC episodes regardless of whether they are short term, long term or residential. One care

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[22] Traditionally, community services did not use the terms 'episode' or 'spell' for inpatient stays. But as these terms are used in the Commissioning Data Set (CDS), they are used throughout the *Approved costing guidance (standards) – community*.

professional will be clinically responsible for the 'episode', even if they work as part of a team.

5.　Within an APC episode, the patient will incur costs from the care given by staff, the use of consumables, being given medicines and overheads (type 1 support costs) from the ward running costs, such as ward administrator costs.

6.　In some cases, the activities will be provided by staff from another organisation that provides specialist services, or GPs who provide ward medical cover.

7.　To accurately record and compare the full cost of caring for a patient, the cost of all activities must be included, no matter who performed them.

8.　The data for community APC activity will come from the Commissioning Data Set (CDS), as described in Standard IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2. This requires all providers to group this data to healthcare resource groups (HRGs).

9.　Specialist palliative care and rehabilitation services are included in this dataset as the episode data will unbundle to HRGs according to their area of care. Community providers should ensure their clinical coding is sufficient to enable the appropriate HRGs to be unbundled.[23]

# Approach

## General

10.　Costs on a ward will include:

- nurses, healthcare assistants and support workers providing care and supervision
- junior doctor tasks
- ward rounds by the lead medical staff member with other staff types (if any)
- patient-specific consumables
- non patient-identifiable medicines (ward stock medicines)

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[23] The community technical focus group is looking at the practicalities of this. If you have an opinion, please contact us at costing@improvement.nhs.uk.

- medical and surgical equipment (ward equipment)
- overheads (type 1 support costs) relating to the costs of running the ward (including admission and discharge administration)
- observations and activity by ward staff
- multidisciplinary team (MDT) meetings for the review of several admitted patients but with patients not present[24]
- therapies and interventions – actions taken to improve or manage a condition or frailty
- specialing or other one-to-one care, such as one-to-one nursing care for a patient with dementia in an urgent care medical ward.

11. The costing process categorises these into different activities that will gather resources for wards. The three main activities are:

- ward care – relates to nursing costs, consumables and medicines at an expected level of patient acuity
- ward rounds – medical staff input to wards, often with other staff present
- supporting contacts[25] – any care professional from a different service area visiting a patient on the ward.

## Ward care

12. Admitted patients incur costs just by being on a ward. The 'accommodation' and basic care costs are allocated to the ward care activity, driven by length of stay in hours and minutes. The CDS includes date and time as required fields.

13. The fields in Table CM13.1 should be used as the cost driver.

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[24] Costing of clinical MDT meetings during an admission should follow Acute/Mental Health standard CM9: Clinical MDT meetings as appropriate, and not be included as part of ward care costs.
[25] Supporting contacts are a superior costing method.

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**Table CM13.1: Excerpt from Spreadsheet IR1.2 showing the patient-level field requirements for calculating length of stay by ward**

| Field name | Field description |
|---|---|
| 'Start date (ward stay)' | The start date of a ward stay |
| 'Start time (ward stay)' | The start time of a ward stay |
| 'End date (ward stay)' | The end date of a ward stay |
| 'End time (ward stay)' | The end time of a ward stay |
| Ward code | Unique identification of a ward within a healthcare provider to which the patient was admitted |

14. 'Acuity', as defined in this standard, describes the level of resource a patient uses due to their condition. The standard level of acuity is understood from the type of ward – for example, those with a higher staffing ratio will accommodate patients with higher acuity.

15. Unless otherwise informed, you can expect that all patients on the same ward will use resources at a similar rate; these will be allocated according to the prescribed rules in Spreadsheet CP3.3.

16. Where a patient receives more care than others on the same ward, their acuity will drive a higher use of resources. As a superior method you can use available information on acuity within a ward to weight the allocation of cost to more accurately reflect resource use; see SCM3 in Spreadsheet CP3.5.

17. Use activity ID: SLA097; Ward care to include these expected levels of resource use.

18. The CDS does not contain acuity information, so if any patients differ significantly in their resource use from what is normal for the ward they are on, you will need to obtain this information from a local information source and input it into the 'acuity level' field in the APC feed (feed 1a), as shown in Spreadsheet IR1.2.

19. If your community provider has a high dependency ward, you should refer to Standard CM6: Critical care, and use activity ID: SLA044; High dependency unit – ward care.

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20. The CDS for a single patient will contain a row for each ward that the patient spent time on – identified by the field 'ward code'. More than one ward can be recorded, in patient journey date order (see Table CM13.2). Wards may differ in their costs, so to cost an individual patient's 'journey' appropriately, you need to know what wards the patient was on.

**Table CM13.2: Examples of how patients are shown in the admitted care dataset hierarchy**

| Patient A | | |
|---|---|---|
| Spell | Episode 1 | Ward A |
| | | Ward B |
| | Episode 2 | Ward C |

Patient A was admitted to Ward A, moved to Ward B, then transferred to a second care provider and moved to Ward C, from where they were discharged.

| Patient B | | |
|---|---|---|
| Spell | Episode 1 | Ward B |
| | | Ward C |

Patient B was admitted to Ward B and moved to Ward C from where they were discharged.

21. As the CDS requires ward information and has been mandated, it is the accepted data source for ward information. However, where the CDS in your organisation does not yet include sufficient ward information, your APC feed (feed 1a) may take data from different parts of your patient administration system (PAS) or you may use the ward stay feed (feed 4).

22. You should use the fields shown in Table CM13.1.

23. Specialist palliative care and rehabilitation services will have a 'core' HRG and 'unbundled' HRGs in the dataset. You should ensure the cost is applied to the correct HRG. Where the whole episode of care is within the specialist area, all

the cost should be in that episode of care, leaving a core HRG with a zero cost.[26]

## Ward rounds

24. Formal ward rounds are usually driven by the lead healthcare professional, who may be a member of the medical staff. They are less common in community settings than in acute settings. Where GPs provide medical cover, they may lead or participate in ward rounds.

25. To record ward rounds, use the activity ID: SLA098; Ward round, to show the cost of the time medical staff spend interacting with patients in this manner.

26. Table CM13.3 is an excerpt[27] from Spreadsheet CP3.3 showing the resource and activity links to use for community wards.

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

**Table CM13.3: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for community ward costs.**

| | Activity | |
| --- | --- | --- |
| **Resource** | **Ward care** | **Ward round** |
| Patient-specific consumables | £X | |
| Nurse | £X | |
| Healthcare assistant | £X | |
| General practitioner – secondary care | | £X |
| Specialist nurse | | £X |
| Advanced nurse practitioner | | £X |

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[26] Please note, as per Standard IR1: Collecting information for costing, the rehabilitation unbundled HRGs are calculated per day  and the specialist palliative care unbundled HRGs are grouped on an episode basis.

[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.

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## Supporting contacts from therapists or other care professionals

28. Healthcare professionals external to the ward may provide contacts while the patient is admitted – for example, where a specialist therapist from another service visits the patient on the ward.

29. This activity will not be part of the standard care provided on the ward. The cost is likely to be part of another service area's expenditure. The cost should be matched to the patients who benefitted from the activity, rather than patients in another service area (or organisation).

30. This activity should be entered into the supporting contacts feed (feed 7). The activity and cost can then be matched to the correct patient. This feed is a superior costing method. This is described in more detail in both Acute and Mental health standard CM1: Medical staffing and Community standard CM3: Non-admitted patient care.

## Group sessions[28]

31. Admitted patients may have access to group sessions such as therapy, supervised sport, cookery or condition management. Patients accessing these activities use more resources than those on the same ward who do not.

32. Where these sessions include all patients on the ward and are run by the staff from the ward budget, which is already allocated equally to all patients on the ward, there is no requirement to separate the cost and show it as a group session on the ward.

33. However, the supporting contacts feed[29] (feed 7) should be used to allocate cost to patients attending group sessions where:

- the costs of running the sessions are not in the ward budget – for example, a physiotherapist attends the ward once a day to hold a mobility group or
- only some of the ward's patients attend the group.

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[28] Activity associated with group activities should be recorded as a contact in your APC or NAPC data feed. For more information, see Standard IR1: Collecting information for costing.
[29] This feed is a superior costing method.

34. Where an acuity measure is used in the ward allocation method, you should consider whether allocating the group's ward costs to all patients on the ward would result in each patient receiving an appropriate cost.

35. You should follow the materiality principle when prioritising work on group sessions.

36. For further information on group sessions see Standard CM14: Group activities.

## Non patient-identifiable and patient-identifiable medicines

37. Patient-identifiable medicines dispensed during an admission should be matched to the APC episode using the prescribed matching rules in Spreadsheet CP4.1 and the medicines dispensed feed (feed 10).

38. Non patient-identifiable medicines costs should be allocated across all the patients on the ward.

39. For more detail, please refer to Standard CM10: Pharmacy, medicines and blood services.

## Consumable items and equipment

40. Please refer to Standard CM21: Clinical non-pay items for more information on the treatment of these costs.

# CM16: Sexual health services

Purpose: To ensure sexual health services are costed consistently.

## Objective

1. To ensure costs for providing sexual health services in an admitted patient care (APC) or a non-admitted patient care (NAPC) setting are allocated appropriately.

## Scope

2. All activity provided by sexual health services.

## Overview

3. Sexual health services offer a range of services to those who have, may have or are at risk of sexually transmitted infections, including:

   - diagnosis and treatment
   - education
   - family planning services
   - support for sexual assault victims
   - provision of surgical and medical terminations of pregnancy
   - psychosexual medicine.

4. Patients can be treated in both APC and NAPC settings.

5. Some elements of this care will be under the formal medical specialty of genitourinary medicine (GUM).

## Community costing methods

6. Due to information governance constraints on sensitive and legally restricted data, patient information for some sexual health services will be anonymised. Therefore, we are aiming to cost **a** patient, not **the** patient, accessing sexual health services. This should not mean there is no record of the patient's care – such a record is important for patient safety. But it may not be available for costing in the same way as for other NHS patients.

# Approach

7. You need to follow the same costing process as defined in the costing process standards for the APC admission and NAPC contacts where patient-identifiable information is available.

8. Sexual health is not in scope of the Community Services Data Set (CSDS). Sexual health services may record formal medical NAPC contacts (GUM) in the outpatient contact section of the Commissioning Data Set (CDS) or hold it locally in a separate data system.

9. You will need to speak to your informatics team to determine where the information is captured and recorded, to obtain an appropriate information feed: see Standard IR1: Collecting information for costing and the sexual health feed (feed 17) in Spreadsheet IR1.2. This will be a locally agreed feed.

10. If no patient-level activity is available and your costing system needs to work with a patient-level structure, you can create proxy records.

11. Where sexual health services have a patient-level record for the activity, but it is not accessible by the main patient administration system (PAS), a pseudonymised patient record should be obtained and used for costing.

12. The cost of sexual health services should be shown in cost centre XXX613; Sexual health/GUM care. If multiple services are within the sexual health costs in your general ledger, you may customise the XXX in your cost ledger to ensure the cost flows to the appropriate resource for allocation.[30]

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[30] See also Standard CP2: Clearly identifying costs.

## Community costing methods

## Consultations

13. The staff cost of the consultation will map to the appropriate staff resource ID shown in Spreadsheet CP2.1.

14. Where the patient receives a consultation for sexual health only, use the activity ID: CMA312; Sexual health/GUM care. Where they receive integrated sexual health and family planning, use the activity ID: CMA334; Integrated sexual health and family planning care. The cost drivers for allocating both are duration of appointment and the care professional(s) in attendance.

15. The consultation activity ID will include the cost of taking bloods or swabs for testing and sending them to the laboratory, but not the cost of the test processing in the laboratory. This is costed to a separate activity ID from the consultation, and then matched to the patient contact in accordance with Standard CP4: Matching costed activities to patients, so the overall cost of the patient visit to the sexual health service includes all identifiable costs.

## Sexual health tests

16. A sexual health test is the pathological test or group of tests to determine type of condition or cause. This is the activity of receiving the blood test or swab sample at the relevant laboratory and processing it, and the cost of consumables, staff/machine processing time and the test. In this way, local laboratory costs can be identified separately from those of contacts, and may be compared to those of an outsourced laboratory.[31]

17. Not all patients will undergo a test during their contact. Therefore, the cost of the test should show up as a separate activity from staff time. You should include sexual health tests in the pathology feed (feed 8) and match it to the contact record for the patient, to ensure the cost is attributed to the correct patient. Use the activity ID: CMA306; Sexual health testing for the cost of the test.

18. The cost of taking the blood/swab sample is usually associated with the consultation with the sexual health professional, and therefore should be included as part of that contact. Only include the associated contact costs for

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[31] Please note, the cost of outsourced tests will include consumable and other variable costs as well as support costs.

taking the sample if the test is carried out separately from the sexual health consultation – for example, in a separate laboratory clinic room by a non-sexual health professional.

19. If your sexual health test information comes from a pathology service dataset (including outsourced) other than the main pathology lab, add its data to the main pathology feed (feed 8).

20. For pathology diagnostics, the test should be matched to the contact where it was taken, in accordance with Standard CP4: Matching costed activities to patients. You should follow the matching rules for pathology in Spreadsheet CP4.1.

21. Sexual health tests may be performed by a different provider from the one where the contact took place. The information should be available to your organisation at patient level, in accordance with Standard CM8: Clinical and commercial services supplied or received. Subject to confidentiality agreements, you should be able to use this information to allocate cost to the patient contact.

22. You should use the following activities for sexual health and family planning:

- Resource ID: CMA306; Sexual health testing
- Resource ID: CMA312; Sexual health/GUM care
- Resource ID CMA334; Integrated sexual health and family planning care.

23. Table CM16.1 is an excerpt[32] from Spreadsheet CP3.3 showing the resource and activity links to use for sexual health and family planning.

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

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[32] 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.

## Community costing methods

**Table CM16.1: Excerpt from Spreadsheet CP3.3 showing resource and activity links for sexual health service costs**

| Resource | Activity | | | |
| --- | --- | --- | --- | --- |
| | Sexual health testing | Sexual health/GUM care | Integrated sexual health/ family planning care | Outpatient care |
| Technician | £X | | | |
| External contracts – clinical | £X | | | |
| Clinical scientist | £X | | | |
| Medical and surgical consumables | £X | | | |
| Specialist nurse | | £X | £X | |
| Consultant | | | | £X |

## Admitted patient care

25. Patients admitted overnight or as day cases primarily for sexual health will usually be recorded under Specialty 360: Genitourinary medicine (GUM) on the APC feed (feed 1a). The type of procedures performed will be clinically coded and should be costed in the same way as for other admitted patients.

26. Where an admitted patient receives a sexual health test, this can be included on the pathology feed (feed 8). It will show up as a separate activity but still be an identifiable part of the total cost of the admitted episode, whichever specialty the patient is admitted under.

27. If a patient admitted under a specialty other than GUM receives a bedside consultation with a sexual health professional, the contact should be recorded on the supporting contacts feed (feed 7) and be a separately identifiable part of the patient episode.

## Community costing methods

28.  Sexual health or GUM services may use theatres. For guidance on the costing of theatres, refer to Standard CM5: Theatres and special procedure suites and Standard CM21: Clinical non-pay items.

# CM17: Dental services

> Purpose: To ensure costs for dental services are allocated consistently.

## Objective

1.  To ensure costs for providing dental services are allocated appropriately, including community services and dental hospitals.

## Scope

2.  All activities provided by dental services.

## Overview

3.  Dental services are provided across various settings including:

    * planned outpatient clinics in a hospital or health centre, whether specific for dental services or not
    * outpatient appointments in a domiciliary setting
    * outpatient appointments in a high street setting
    * emergency dental departments excluding dental emergencies treated in type 1 A&E departments
    * patients admitted to a ward under dentistry or another specialty
    * prison services.

4.  Activity for dental patients will be recorded in provider systems in various ways:

    * in the main patient administration system (PAS) as admission episodes (included in the admitted patient care (APC) feed)
    * in the main PAS as outpatient attendances (included in the non-admitted patient care (NAPC) – community feed (feed 3c)) or NAPC feed (feed 3a)

### Community costing methods

- in a separate local system for community dental activity.

5. The data required for the dentistry feed (feed 18), as shown in Spreadsheet IR1.2, is the community dental activity. It should only include dental activity not covered by the APC or NAPC feeds.

6. Where the patient has been admitted, the unit for costing is the episode. This should be part of the APC feed (feed 1a), and costing processes should be applied as for other patient episodes.

7. For non-admitted patients seen in hospital outpatient clinics, the unit for costing is the outpatient attendance. This should be part of the NAPC feed (feed 3a) and costing processes applied as for other outpatient attendances.[33]

8. The unit of dental activity (UDA) is included in the dentistry feed (feed 18) so that organisations can produce cost reports for UDA as needed.[34]

## Approach

9. Where the community dental contacts are not recorded in the PAS but as UDAs in a separate clinical information system, that local data should be used to supply the dentistry feed (feed 18). The patient contacts can then be costed under the costing process standards.

10. Map the general ledger to the cost ledger in accordance with the costing process standards, which will ensure the resources for dentistry are identifiable. The likely cost centres in the cost ledger are XXX033 Dental services and XXX039 Dental laboratory

11. Use the resources linked to these cost centres. The most important ones for dental services are listed in Table CM17.1.

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[33] If dental services are provided in the patient's residence and recorded on the Community Services Data Set (CSDS), these should be entered into the NAPC – community feed (feed 3c)

[34] "UDAs are a measure of the amount of work done during dental treatment. More complex dental treatments count for more UDAs than simpler ones." NHS England (2018) https://www.england.nhs.uk/statistics/2018/05/03/dc0136785_mar18/

## Community costing methods

**Table CM17.1: Excerpt from Spreadsheet CP3.1 showing resources for dental services**

| Resource ID | Resource | |
|---|---|---|
| MDR053 | Dental laboratory technician | Technicians who use moulds taken during an outpatient attendance to manufacture dental appliances such as braces and mouth guards. These are fitted in subsequent appointments. |
| MDR057 | Dentist | Medical staff professionally qualified as a dentist. |
| MDR058 | Dental nurse | Specialist nurse in dentistry – all bands. |

12. Review the prescribed list of activities in Spreadsheet CP3.2 and by working with the service team identify those your dental staff deliver. Table CM17.2 lists the activities to use for dental services.[35]

**Table CM17.2: Excerpt from Spreadsheet CP3.2 showing activities for dental services**

| Activity ID | Activity | |
|---|---|---|
| MDA076 | Dental care | Dental care for routine dental services. |
| MDA077 | Specialised dental care | Specialised dental care should include orthodontic and other specialist activities. |
| MDA078 | Emergency dental care | Emergency dental care for out-of-hours services, emergency surgery and other unplanned services (excluding type 1 (A&E) emergency dental treatments). |

13. With your service team, you should agree how the patient activities are identified from the data in the dentistry feed (feed 18).

14. You will need to find out from your dentistry service what information is available about dentistry in prisons. If suitable information is not recorded, you should work with the service and your informatics team to record and obtain it.

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[35] Definitions for these activities will be developed with the community technical focus group for 2019.

## Community costing methods

Prison contacts will be identified using the 'location' field in the relevant NAPC feed (feeds 3c or 3a) or it can be added to the dentistry feed (feed 18).

15. Where the patient has a contact for oral health promotion, but no other investigations or treatments, this should be recorded as activity ID: MDA076; Dental care.

16. Table CM17.3 is an excerpt[36] from Spreadsheet CP3.3 showing the resource and activity links to use for dental service contacts.

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

**Table CM17.3: Excerpt from Spreadsheet CP3.3 showing resource and activity combinations for dental service contacts with patients**

| Resource | Activity | | | |
| --- | --- | --- | --- | --- |
| | Dental care | Specialised dental care | Emergency dental care | Dental laboratory work |
| Medical and surgical consumables | £X | £X | £X | £X |
| Dentist | £X | £X | £X | £X |
| Dental nurse | £X | £X | £X | |
| Patient-specific consumables | £X | £X | £X | |
| Dental laboratory technician | | | | £X |
| External contracts – clinical | | | | £X |

## Consumable items

17. Where community (APC/NAPC) dentistry contacts use medical and surgical consumables – including bespoke and orthodontic devices – in assessing and

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[36] 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.

treating patients, allocate the cost to the patient according to Standard CM21: Clinical non-pay items.

## Internal dental laboratories

18. Dental laboratories within your organisation should use the relevant resource for the type of pay/non-pay items. Where they provide a service to your organisation's own patients, use activity ID: MDA075; Dental laboratory work to allocate the cost to the patients.

19. Where this activity does not relate to your own patients, but to those of other providers, again use activity ID: MDA075; Dental laboratory work but treat this as commercial activity by applying the costing processes in Standard CM8: Clinical and commercial services supplied or received.

## Dental hospitals

20. The costing standards also apply where the dental service is located within a dental hospital. Please refer to Acute standard CM1: Medical staffing, standard CM5: Theatres and special procedure suites and Community standard CM13: Admitted patient care.

# CM19: Wheelchair services

Purpose: To ensure costs for wheelchair services are allocated consistently.

## Objective

1.  To ensure costs for providing wheelchair services are allocated appropriately, including purchase of equipment and patient contacts for assessment, fitting, review, maintenance and repair.

## Scope

2.  All activities provided by wheelchair services.

3.  All wheelchairs, accessories and equipment associated with the wheelchair provided and/or maintained/repaired by the service.[37]

## Overview

4.  NHS England states: "Wheelchairs provide a significant gateway to independence, wellbeing and quality of life for thousands of adults and children. They play a substantial role in facilitating social inclusion and improving life chances through work, education and activities that many people who do not need wheelchairs take for granted".[38]

5.  The wheelchair service issues a wide range of equipment to patients with a wide variety of conditions and requirements. The cost per patient will vary accordingly. Existing methods of recording contacts with non-admitted patients are insufficient to provide appropriate costs for the assessment, issue and review of wheelchairs.

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[37] Some wheelchairs and accessories/equipment are supplied by charities or other third parties. Only the cost incurred by the provider should be included in the costing information.
[38] NHS England *Improving wheelchair services* https://www.england.nhs.uk/wheelchair-services/

**Community costing methods**

6.   Wheelchair services were introduced into the reference costs in 2013/14; this represented the first time such NHS costs were submitted nationally (see paragraphs 604 to 617 in the *National cost collection guidance 2019* for current information on collected data).[39]

7.   Currently there is no national clinical dataset submission for wheelchair services patient-level activity. Therefore, the costing system should include an information feed based on local data submitted to NHS Digital's National Wheelchair Data Collection.[40]

8.   This standard will support NHS England in its development of currencies and tariffs for wheelchairs.

9.   Two information feeds have been introduced for wheelchair contacts feed (feed 19a) and wheelchair equipment (feed19b); see Standard IR1: Collecting information for costing and Spreadsheet IR1.2. These enable the PLICS to maintain separate costing of wheelchair contacts and equipment, with the potential to build in matching of wheelchair information to the wider patient care pathway in the future. The feeds also capture the additional information required for wheelchair currencies.

# Approach

10.  Data for wheelchair contact activity and equipment are submitted in the National Wheelchair Data Collection to NHS Digital. Some services are also commissioned directly at patient level, and patient-level detail for these will be held locally to manage the service and comply with external information requirements, including those for national currencies. Information is therefore available for costing.

11.  Your organisation will record wheelchair service contacts either:

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[39] https://improvement.nhs.uk/resources/approved-costing-guidance-2019/#h2-national-cost-collections-guidance-2019

[40] This dataset is submitted at aggregate level. Collection guidance can be found at: https://www.england.nhs.uk/publication/wheelchair-services-national-wheelchair-data-collection-guidance/

- in the main PAS as outpatient attendances, included in the non-admitted patient care (NAPC) feed (feed 3a)[41]
- in a separate local system for wheelchair service activity.

12. Costs of the wheelchair equipment provided will be recorded in a local system or spreadsheet and should include the cost of the items issued per patient.

13. Most wheelchair services are provided during NAPC clinics in a hospital or health centre. However, some assessments and issuing of wheelchairs may occur while the patient is an inpatient, eg following amputation surgery. You should cost the equipment and contacts using the prescribed resources and activities in Spreadsheets CP3.1 and CP3.2, so the approach is consistent with other services. You should not match the wheelchair contact or equipment to the admitted episode as wheelchair services are not currently included in the admitted episode.

14. In the standardised cost ledger, you should use cost centre XXX606: Wheelchair services; this can be customised using local digits to replace the XXX if you need to disaggregate costs for standard and specialist complex services.

## Wheelchair service contacts

15. The NAPC wheelchair services data should be built into the wheelchair contacts feed (feed 19a) as shown in Standard IR1: Collecting information for costing and Spreadsheet IR1.2. There are national commissioning currencies for wheelchairs, and these feeds open the potential to collect these in future PLICS national collections. Dataset items to facilitate reporting of the currencies have been included in the wheelchair feeds.

16. The contacts can then be costed using the field 'clinical contact duration of care contact', in accordance with Standard CP2: Clearly identifying costs and Standard CP3: Allocating costs to activities.

17. Table CM19.1 lists the key resources to use for wheelchair service contacts.

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[41] Wheelchair contacts are not included from the current Community Services Data Set (CSDS) version v1.0 6.

## Community costing methods

**Table CM19.1: Excerpt from Spreadsheet CP3.1 showing some service-specific resources for wheelchair staffing**

| Resource ID | Resource | Resource description |
|---|---|---|
| CMR302 | Wheelchair/rehabilitation engineer/technician | Salary of staff member trained in technical assessment, maintenance and repair of wheelchairs and the supporting work with the wheelchair user. Includes Field service engineer. |
| CMR311 | Wheelchair/rehabilitation engineer/technician assistant | Salary of staff member trained in technical assessment, maintenance and repair of wheelchairs, and the supporting work with the wheelchair user. Bands 1 to 4. Includes assistant practitioners. |
| CMR314 | Wheelchair/rehabilitation therapist | Salary of staff trained in assessment, fitting of patients referred for wheelchair services, including care pathway planning and follow-up. |

18. Review the prescribed list of activities in Spreadsheet CP3.2 and by working with the service team identify those your wheelchair and support staff deliver.

19. With your service team you should agree how the patient activities are identified from the data in the wheelchair contacts feed (feed 19a).

20. Table CM19.2 is an excerpt[42] from Spreadsheet CP3.3 showing the resource and activity links to use for wheelchair service contacts.

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

22. We note that wheelchair services have specially trained administration staff. They should be identified by band in the same way as other administration staff and their costs allocated to the patients who use the service. In this way, the cost will reflect the additional skills used.

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[42] 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.

## Community costing methods

**Table CM19.2: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for wheelchair service staffing costs**

| Resource | Activity | | | | |
|---|---|---|---|---|---|
| | Wheelchair first assessment contact | Wheelchair repairs/ maintenance contact | Wheelchair handover and clinical fitting contact | Wheelchair review following assessment/ fitting contact | Wheelchair skills practice and other contacts |
| Nurse | £X | | | | |
| Wheelchair/ rehabilitation engineers/ technician assistants | | £X | | | £X |
| Wheelchair/ rehabilitation engineers/ technicians | | £X | £X | £X | |
| Wheelchair/ rehabilitation therapists | £X | | £X | | |

## Wheelchair equipment

23.  Wheelchair repairs and maintenance have a separate cost from the purchase of new wheelchair equipment. Wheelchair equipment should be brought into the costing system in wheelchair equipment feed (feed 19b), as described in Spreadsheet IR1.2.[43] This information will also identify if the equipment was newly issued or issued following repairs/maintenance.

24.  Wheelchair equipment should include chairs, cushions and support equipment. Use the following cost ledger expense codes:

- 7054    EPIOC wheelchairs (powered)
- 7053    Special seating and accessories

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[43] This information is an auxiliary feed and does not need to be mapped to the contact activity. We intend to map this information to the master wheelchair activity in future versions of the standards.

## Community costing methods

- 7052    Wheelchairs (non-powered)
- 7057    Appliances and implants, special cushions.

25.  Wheelchair repairs and maintenance may be:

- performed within the organisation by designated staff – use the expense codes of those staff with the components showing on the cost ledger expense code:

  – 7066    Medical and surgical equipment maintenance/repairs and components

- items sent away to specialist companies – use the expense code:

  – 7067    Medical and surgical equipment maintenance contracts.

21.  Wheelchair equipment, including repairs and maintenance expense items, will map within the cost ledger to the resource ID: CMR303; Wheelchairs.

22.  The allocation method for the wheelchairs is actual cost, based on the information supplied to the costing system from the wheelchair equipment feed (feed 19b).

23.  Table CM19.3 is an excerpt[44] from Spreadsheet CP3.3 showing the resource and activity links to use for wheelchair equipment.

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

**Table CM19.3: Excerpt from Spreadsheet CP3.3 showing resource and activity links for wheelchair equipment costs**

| | Activity | |
| --- | --- | --- |
| **Resource** | **Issue of wheelchair equipment/ components/ accessories** | **Wheelchair repair/ maintenance, including outsourced cost** |
| Wheelchairs | £X | £X |
| External contracts – clinical | | £X |

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[44] 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.

## Other considerations

25. Specialist wheelchair services do not require additional rules for costing, even though this area is not covered by the mandated national wheelchair commissioning currencies.

26. Where patients receive wheelchairs, equipment or accessories that are not funded by NHS commissioning, and they or others such as charities pay for these items themselves, you should match this income to the expenditure so only the net cost is shown.

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