Mandating patient-level costing for NHS community services: an impact assessment

December 2020

Contents

Since 1 April 2016, Monitor and the NHS Trust Development Authority have operated as a single integrated organisation known as NHS Improvement (now NHS England and NHS Improvement). This document is issued in accordance with the duty to carry out and publish an impact assessment of certain proposals, imposed on Monitor by Section 69(4) of the Health and Social Care Act 2012. In this document, therefore, ‘NHS England and NHS Improvement’ means Monitor, unless the context requires otherwise.

Summary

1. NHS England and NHS Improvement proposes to mandate NHS trusts and foundation trusts (referred to collectively throughout as “NHS Trusts”) providing community services to record and report patient-level cost data for all relevant activity using the approaches and methods in the “Healthcare costing standards” [1]. We would mandate this from the beginning of the 2021/22 financial year, with the first collection in 2022, and stop collecting reference costs after the financial year 2020/21[2]. This impact assessment accompanies our consultation document and describes our estimation of the impact of our proposal on NHS Trusts.

2. The Costing Transformation Programme (CTP) aims to collect consistent cost information across all sectors to enable us to better understand the patient pathway by tracking costs and activities across the system. Since 2018/19, patient-level costs have been mandated for NHS Trusts for services, starting with the acute sector in 2018/19, followed by mental health and ambulance in 2019/20. Details of the timetable can be seen at costing mandation project - timeline[3].

3. Collecting the more detailed and accurate patient-level costs in the community sector would:

    - enable community providers to compare patient pathways and costs with peers, helping them identify and reduce unwarranted variation
    - produce more accurate cost data that would improve the accuracy of the local prices, helping to strengthen efficiency and quality incentives and improve sustainability across the service in the longer term
    - improve understanding of patient pathways between NHS community providers and the rest of the sector, facilitating new care models and more integrated care designed around the needs of the patient.

[1] https://www.england.nhs.uk/approved-costing-guidance/ and selected the relevant financial year
[2] The same services are covered in reference costs and patient level costing
[3] https://webarchive.nationalarchives.gov.uk/20200501110529/https://improvement.nhs.uk/resources/costing-mandation-project/

4. We are aware that there is a cost associated with implementing patient-level information and costing systems (PLICS), and this document contains our estimates of this cost. However, as with previous impact assessments[4] for other sectors we believe the benefits for trusts and other users of the data will outweigh the initial investment of time and cost.

5. Engagement with NHS Trusts providing community services has been good. The number of trusts involved has increased from three in 2017/18 to 42 in 2019/20. Their feedback and that from the Community Technical Focus Group has been invaluable in supporting the implementation of CTP and we thank all the trusts that helped draft and develop the costing standards.

6. Although PLICS for community services is still in its infancy, some benefits are beginning to be realised and more are expected. The Community Technical Focus Group has found that moving towards implementing patient-level costing has started improving the recording of both activity and cost data which supports better decision making, planning of services and bids for additional services.

7. We are also recommending ceasing the collection of reference costs data as running two cost collections would impose a significant burden on the sector and many teams would struggle to submit both returns. By concentrating on a single return, providers and commissioners will be able to start using the patient-level data sooner. This is consistent with the mandation across the other sectors over the last few years.

8. However, this impact assessment acknowledges that there are risks to this proposed approach, including:

    - Some NHS Trusts and commissioners use block contracts or cost and volume contracts, which are based on reference costs information which will not be available after 2020/21. The new patient-level cost data will need to be used as part of the move by commissioners and providers to a blended contract process.
    - The level of cost information collected through PLICS is significantly more detailed than reference costs. Some NHS Trusts may not have the required

[4] https://webarchive.nationalarchives.gov.uk/20200501110529/https://improvement.nhs.uk/resources/transforming-patient-level-costing/

information meaning that they will struggle to adhere to the PLICS standards.

- There are upfront costs of setting up a patient-level costing system for the 2% of trusts which don't yet have the required software. There may also be additional IT costs (such as new servers, etc).
- It is expected there will also be additional costs for the trust around ensuring the completeness and accuracy of patient-level data, compared to reference costs. However, improved patient data held locally will be of benefit to planning, operating and transforming patient services, and will help improve accuracy in submissions to national datasets used for analytical and clinical purposes[5]. Over time, we also expect the time and cost taken to produce PLICS will reduce, as much of the financial understanding will become business as usual and data validations will become part of the normal business of the trust.

9. NHS Improvement also recognises the impact that the COVID-19 pandemic may well have on the 170 NHS Trusts who provide community services and would be impacted by this mandation. To address these concerns the following proposals have been made to help facilitate the work the Costing Team does with NHS Trusts to support the implementation of PLICS for community services:

   i) A transition pathway will be produced, to allow trusts to move towards full implementation of PLICS for community services over an agreed number of years. A similar process operates for acute, mental health and ambulance activity and has been welcomed by NHS Trusts.

   ii) A specific working group has been created to support the costing submissions for all sectors. The group is likely to continue to operate in 2021/22 depending on the impact of the pandemic. This work is supported by a Costing Advisory Group (including a sample of trusts across all sectors and other stakeholders) which will support the production of guidance on COVID-19 and more general costing submissions.

[5] For example, the community services dataset (CSDS) is still young and there are known data quality problems in some areas. Improvement to the data driven by the need for good costing data will also support work on data quality by NHS Digital and benefit all users of the data.

iii) Implementing PLICS will reduce the burden on trusts as only one costing submission will be required. This should save the time spent on reconciling costs across two submissions.

iv) The Costing Assurance Programme will be extended to cover community services. The aim of this programme is to support trusts to address issues, identify trusts where additional support is needed and identify improvements in guidance and support produced by NHS England and NHS Improvement.

v) And as with future submissions, the Costing Team will continue to monitor the impact of the pandemic and consider adjusting submissions windows and compliance with costing standards as necessary – processes that are currently in place.

10. This impact assessment presents our assessment of the three options we have considered for implementing patient-level data for community activity. It relates to the proposals we are consulting on. NHS Trusts are requested to read this and respond to the consultation, even if your organisation does not provide community services. We want to understand any concerns other types of providers or organisations have with this proposal. For more information on the consultation process and details of how to provide feedback, see our consultation document[6]. The consultation period will run from Thursday 17 December 2020 to Friday 29 January 2021.

11. Annex 1 explains how implementing the proposal for mandating patient-level costs for community activity would discharge our statutory duties.

[6] https://www.england.nhs.uk/approved-costing-guidance/

Detailed impact assessment

1. This document contains our assessment of the impact of requiring all NHS trusts who provide community services to record and report costs for those services, in line with the methods and approaches in the *Healthcare costing standards for England* ('the standards'). This relates to financial year 2021/22, collected from 2022. The assessment has been carried out in accordance with Section 69 of the Health and Social Care Act 2012. The consultation period for commenting on the proposal begins on Thursday 17 December 2020 and ends on Friday 29 January 2021. For further details on the proposal and how to respond, see our consultation document.

What is the problem being considered?

2. Collecting patient-level information and costing data is key to helping the NHS improve patient outcomes and efficiency and achieve the vision in the Five Year Forward View (5YFV). It also supports the aims of the NHS Long Term Plan[7], by allowing trusts and commissioners to better understand costs and activity flows, so enabling them to "maximise the use of taxpayers investments".

3. The role of costing in supporting these wider objectives was described in our 2015 report, *Patient-level costing: case for change*.[8] The plan for the transition to patient-level costing was described in *Improving the costing of NHS services: proposals for 2015 to 2021*.[9]

4. Currently, NHS Trusts providing community services submit reference costs to fulfil NHS Improvement's provider licence requirements and the conditions equivalent to the licence as specified by NHS Improvement (including NHS Trust Development Authority) as applicable to NHS trusts. Reference costs

[7] https://www.longtermplan.nhs.uk/
[8] https://improvement.nhs.uk/resources/plics-case-change/
[9] www.gov.uk/government/consultations/improving-the-costing-of-nhs-services-proposals-for-2015-to-2021

record the average unit cost to the trust of providing the designated currencies. This information is used by organisations that include:

- NHS community providers and commissioners – to manage their costs, improve their services, and underpin the move to blended payments for contracting purposes.
- Regulators – including NHS Improvement (to understand the sector's costs) and other arm's length bodies, such as the National Audit Office and the Department for Health and Social Care (DHSC) as part of the work on the sector's performance
- Those carrying out cross-sector work to improve clinical outcomes and efficiency, including the implementation of the recommendations in Lord Carter's reviews of operational productivity, and benchmarking between trusts to identify unwarranted cost and job-cycle variation.

5. The processes for submitting reference costs and their accuracy vary considerably between NHS Trusts. Previous reviews of accuracy of reference cost data undertaken as part of the Costing Assurance Programme (focusing on acute providers who also provide community services) found the level of information available for these services was poor. There were a large number of examples where data for services not included in the mandated commissioning data sets (collected and submitted to NHS Digital) was found to be estimated or incomplete - based on information collected for a few weeks or months and extrapolated for the full year.[10] A move to patient-level costing will encourage trusts to put in place better arrangements to collect and understand the level of activity they are providing.

6. When reviewing the data submitted to NHS Digital on community services it was noted that for May 2020 only 62% of community NHS providers were submitting the mandated community services data sets to NHS Digital (an improvement from 42% in October 2019). In mandating patient-level costing, trusts will need to ensure that the mandated community data sets are submitted; this was the key reason that the timetable was delayed by a year to 2021/22.

[10] This includes community dentistry, sexual health, wheelchair services, direct access for non-community for example.

7. As reference costs standards are set on a comply or explain basis[11] we cannot guarantee the comparability of reference costs. Because patient-level costs are at a more granular level and that the methods and approaches for costing will be mandated, errors in counting and costing will be easier to identify, and this should lead to an improvement in the quality of costed data, with a feedback loop informing activity data quality improvements.

8. Reference costs are produced annually and reported at average cost per HRG or another agreed unit. The information is at an aggregate level which cannot be split into types or components of costs and is not linked to the clinical pathway of patients. This does not allow trusts to identify clinical variation – either within a trust or across the sector. This lack of granularity makes it difficult to identify where improvements can be made to provide a better service to patients.

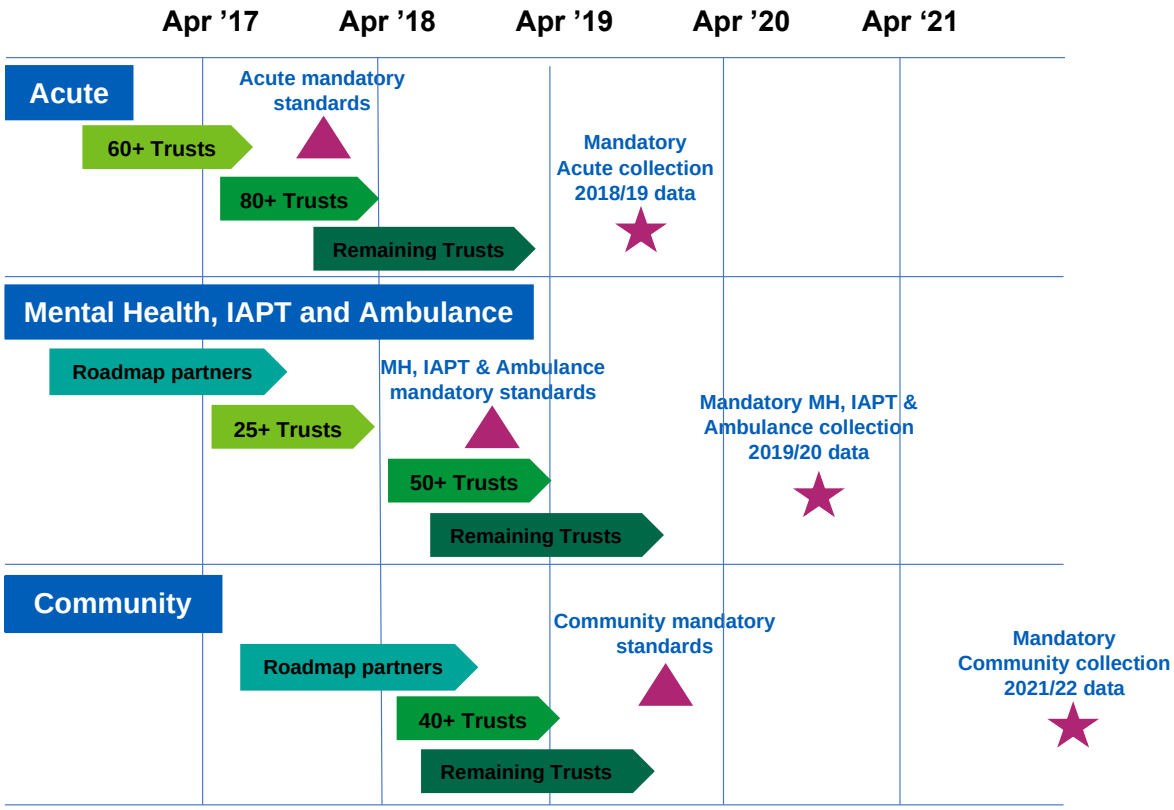
What we propose

9. This impact assessment therefore assesses the costs, benefits and risks associated with mandating submission of patient-level cost data using the Standards for community services provided by NHS Trusts. This would start from the financial year 2021/22, with the first collection in the summer of 2022. Patient-level cost information has already been mandated for acute providers of acute services (2018/19), mental health services and ambulance 999 activity (2019/20).

10. As depicted in Figure 1, mandation of patient-level costing is being rolled out by sector. We expect NHS trusts to start submitting patient-level costs for services that have been mandated when their main activity is mandated. This means that if an NHS Trust providing community services also provides acute or mental health services, they will be expected to submit patient-level costs for all activity covered by PLICS for 2021/22.

[11] **Comply-or-explain** is a regulatory approach used in the UK and other countries for corporate governance and financial supervision. Rather than binding laws, regulators set out a code which listed companies may either comply with, or if they do not comply, explain publicly why they do not.

Figure 1: CTP proposed timeline for mandation of patient-level costing



11. There are 170 NHS Trusts who provide community services. Of these there are:

    - 124 whose main service is acute[12]
    - 27 whose main service is mental health and
    - 19 whose main service is community.

12. Engagement with NHS Trusts providing community services has been good, even with the delay in the mandation timetable as well as the impact of COVID-19. Around 50 trusts attend our technical focus group and they have been instrumental in drafting and agreeing the costing standards. In addition, as noted 42 trusts are now part of our early implementer group, working on the 2019/20 voluntary submission. The plan is to increase this to 80 trusts for the 2020/21 – the last year before PLICS is mandated.

[12] The type of trust is determined by the main service they provide (using completed 2017/18 costing returns, updated for mergers and takeovers etc)

13. Since 2012,[13] NHS Improvement has advocated moving to patient-level costs in preference to continuing with reference costs. Our consultation in 2014 set out a detailed plan and timetable for this move, and feedback was positive. The plan proposed:

    - introducing a single set of standards for patient-level costing for each service (acute, ambulance, mental health and community), enabling them to cost activities consistently[14]
    - the gradual replacement of reference costs with patient level data starting with acute, mental health and ambulance, finishing with community services[15].

14. By mandating a patient-level cost collection with costing standards for all NHS Trusts' data collection, we can achieve four main objectives:

    - Objective 1: Ensure the service adopts patient-level costing. This would ultimately enable us to use patient-level costs as the basis for all cost data in the NHS and to stop mandating reference costs collection, reducing the burden on trusts that are submitting both. This would also support the move to system-wide contracting and costing of services as part of the move to Integrated Care Systems (ICS).
    - Objective 2: Improve NHS Trust performance. The granularity of patient-level cost data can identify how resources are used and inform clinical transformation. Patient-level costing would support local and national work on operational productivity by helping to identify unwarranted variation and opportunities for cost savings that can lead to improved patient outcomes. It would include support for NHS England and NHS Improvement's analysis and clinical effectiveness programmes, including the Getting It Right First Time (GIRFT) project to reduce unwarranted variation and improve patient outcomes, and the Model Community Health (as part of the Model Health System).

[13] *Costing patient care: Monitor's approach to costing and cost collection for price setting* *Costing patient care: Monitor's approach to costing and cost collection for price setting*.
[14] The standards are now being refined to support the greater and increasing integration of services through mergers and reconfigurations to reduce the burden and improve consistency across services.
[15] Some small areas will continue to be collected at aggregate level, such as unbundled services to allow detailed work in these areas.

- Objective 3: Improve the quality and consistency of cost collections, enabling NHS Trusts to compare their costs. We found that participating acute trusts could identify efficiencies and improvements both internally and with external organisations, even when only a limited number were submitting a basic level of patient-level cost data. We expect community providers to benefit from more granular data.
- Objective 4: Improve currencies and currency design. Using patient-level cost data to calculate the prices would improve tariff setting accuracy as we expect trusts to be better able to check the accuracy of data. This data will be also be available for benchmarking. We would use data validation checks and costing audits to show the apparent level of accuracy.

Analysis of options

15. Initially we identified eight options for mandating patient-level costs in the community sector (see Table 1 and Annex 2 for further details). These were reviewed and reduced to three main options.

Table 1: Initial options review

Initial option	Summary	Included in impact assessment?
A	**The 'do nothing' scenario:** Reference costs (RC) collected annually and Patient-level costs (PLC) collected annually on a voluntary comply-or-explain basis	Yes
B	**Mandating RC standards:** RC collected annually with use of standards mandated. PLC remain a voluntary annual collection	No
C	**Mandating annual patient- level cost with dual running of RC for two years:** patient- level cost and standards mandated for annual submission from 2021/22 for NHS community activity, with dual running of RC for the following two years	Yes
D	**Mandating annual patient- level cost without dual running:** patient- level cost and standards mandated on an annual basis for all NHS community providers, and RC ended after 2020/21 for community activity	Yes

Initial option	Summary	Included in impact assessment?
E	**Mandating quarterly collection of patient-level costs:** patient- level cost and standards mandated for annual submission from 2021/22 for NHS community activity, moving to quarterly/monthly for 2023/24, and RC collected annually for the following two years (ending in 2023/24)	No
F	**Mandating RC standards from 2021/22 and mandating patient- level cost from 2022/23:** Standards mandated for 2021/22 for annual RC submission and CTP patient- level cost annual submission, with mandation of CTP patient- level cost from 2021/22 and RC ending in 2020/21	No
G	**Phased mandation of patient- level cost and standards:** The early implementers in 2020/21 and the remaining trusts in 2021/22, with RC collected for all community activity until patient- level cost is implemented	No
H	**Phased mandation of patient- level cost and standards with dual running of RC and moving to quarterly collection after two years:** The early implementers in 2020/21 and the remaining trusts in 2021/22, with RC collected until patient- level cost is implemented, then moving to quarterly submission two years later	No

16. Based on our analysis, summarised in Annex 2, we shortlisted options A, C and D for the impact assessment.

- **Option A**: represents the status quo, with no mandatory requirement for patient- level costing. It is included as the business-as-usual option that all other options are assessed against. It is referred to as Option 1 in this document.
- **Option C**: the original BDO[16] proposal for the CTP did not include a timetable for phasing out reference costs and no decision has been taken

[16] We commissioned BDO LLP to undertake a review to develop costing, cost information and cost collection in 2014.

on the timing. We have assumed an appropriately cautious estimate with two years of dual running. This is referred to as Option 2 in this document.

- **Option D (preferred)**: Like Option C but with no dual running of reference costs for community services. Given that there are no national prices for community services, we believe it would be possible to move directly from reference costs to patient- level costs with no dual running, reducing the burden on the sector. Other regulators, stakeholders and trusts tell us this is not an issue that would adversely affect recommending this option. This is referred to as Option 3 in this document.

17. In the rest of this impact assessment we refer to the three assessed options as Options 1, 2 and 3.

Option 1

Business as usual

Table 2: Estimated cost of Option 1

	Total average annual cost per trust	Total cost over 10 years[17]
Option 1	£169,569	£228,132,098

How would Option 1 work in practice?

1. This is the business-as-usual option. Under this option

   i) the costs for 151 NHS trusts whose main service is acute or mental health would continue to be collected at patient level; and their community activity would be submitted at an aggregate level

   ii) the remaining 19 trusts whose main service is community would continue to submit aggregate level data for all their services

   iii) the standards would remain on a comply-or-explain basis[18]

   iv) engagement in the voluntary PLICS programme for community services would remain as is for 2019/20 and then reduce over a four-year period if this was not mandated.

Assumptions

2. We made the following assumptions in costing this option:

[17] This if the total value multiplied by GDP deflator and Discount rate to give the Net Present value (see Annex 7). The net **Present value (PV)** is the current value of the sum of the discounted future costs (or benefits) adjusted for a discount factor of 3.5% as recommended

[18] To note: acute and mental health trusts are already mandated to apply the standards. Very few costing standards apply solely to community services. Therefore, the comply or explain protocol would mostly relate to the 19 community service providers.

- For trusts whose main service is not community (151 trusts), we have calculated the costs of submitting patient- level cost data for mandated services and aggregate level data for community services.
- If patient-level costing is not mandated, we expect the number of voluntary submissions for community services to reduce over four years from Year 2[19] onwards, as trusts focus on submitting the mandatory return. As in the acute impact assessment, we assume that without mandation no NHS Trusts would submit patient-level community costs in 2025/26. Some might continue to collect it for internal use, but they would be unlikely to submit it if this was not mandatory.
- A variety of processes and information were used to calculate staff costs.
  - We used the Agenda for Change (AfC) pay proposed in the new pay settlement up in 2020/21, and after that included an estimated average uplift of 2.5% over three years (equivalent to the average pay increase under the agreed AfC proposal).
  - We included the on-cost charge in accordance with NHS Employers' guidance, updated for the increase in Employers Superannuation from 2019/20 onwards.
  - We used information collected during on-site visits and reference costs surveys, updated for additional information collected in the summer of 2020 to calculate the time trusts spend producing their current costing information and submissions. We did not include any costs for internal financial functions, such as producing service-line information or budgetary control purposes.
- We based annual cost of the IT systems (for both reference costs and patient-level costs) on the midpoint of suppliers' costs and including an element of supplier consultancy time. We assumed that inflation will increase these costs by 5%[20] per year.
- We used information from business cases provided for trusts without a PLICS system (all sectors) but have not included the cost of any other new finance systems or hardware.
- We based the cost of voluntary patient-level cost submissions on information from roadmap partners and findings from acute and mental

[19] As with the acute review, we believe that the number of trusts submitting patient-level data would drop by 25% a year.
[20] Based on feedback from suppliers and consistent with our impact assessment for acute trusts.

health trusts, updated for information from the community surveys in 2019 and 2020.

Monetised costs of this option

3. As this is the business-as-usual option, the future costs are similar to those already incurred across the sector. They include the costs of continuing to submit reference costs and the costs of voluntary patient-level costs (which we assume would fall over time if we did not mandate as fewer trusts choose to submit).

4. We have included a cost or the impact of the burden for the 151 acute and mental health providers who will need to submit reference cost information, so effectively running two costing systems or two modules of the same system which calculate costs on very different bases. We believe, based on early feedback from other sectors and those trusts involved in the various voluntary collections, that this would be a significant burden.

5. For detailed analysis of the monetised costs see Table 3.

Unmonetised costs of this option

6. In addition to the financial costs of the business-as-usual option, there are unmonetised performance costs of not mandating patient-level costs (essentially the unrealised performance benefits of patient-level costs described in Option 2). The business-as-usual option means cost data would continue to be collected at an average cost level for community activity, so we would expect limited additional cost savings and inability to make detailed cost comparisons; creating a split in the usability of cost data. This could reinforce the unhelpful perception that community is a “Cinderella” service compared to other services and could mean that costing community services would continue to be seen as a finance-only exercise.

7. Without mandating the standards, trusts would continue to account and report inconsistently on community costs and activity, which would continue to undermine the accuracy of this data and make it difficult to compare costs or understand the complete patient pathway.

Costs excluded from analysis of this option

8. We excluded several costs from this and other options:

- The cost of calculating Education and Training (E&T) costs. We are currently working with Health Education England (HEE) on an E&T data collection for all types of provider and once that is complete we would assess - as part of the post-implementation review (see 'Why we prefer Option 3') - the time and cost of any proposed changes.
- There would need to be a programme to assure the accuracy of data submitted regardless of the cost collection in place. The current costing assurance programme[21] focuses on all costs in acute and mental health services but will be extended to all services in the future, irrespective of sector or collection model.
- We assumed no reduction in the cost of the NHS England and NHS Improvement Costing Team. Although much of the team's work currently focuses on patient-level costs, other work includes managing the reference cost part of the national cost collection and managing the voluntary collection of patient-level data.
- Any costs incurred by NHS Digital in collecting and disseminating this information.

Monetised and unmonetised benefits of this option

9. We assumed this option would have no specific additional benefits. The new standards – which would remain on a comply-or-explain basis – and the costing assurance programme are likely to drive some improvement in the accuracy of costing, which could in turn lead to some efficiency savings. Trusts could, for example, see some internal benefit to costs and patient pathways from the voluntary patient-level cost data. We believe that progress would be slow due to the known limitations of reference costs as a decision-making tool.

10. However, as neither patient-level costs nor the standards would be mandated, we believe the issues with consistency of costing would continue and detract from the benefits of the Model Health System analytics. Feedback on

21 https://webarchive.nationalarchives.gov.uk/20200501110529/https://improvement.nhs.uk/resources/costing-assurance-programme/

reference costs from other data users indicates that providing more accurate and granular data would reduce the need for large amounts of data cleansing and allow policy-makers better insights into the sector.

11. We assumed this option would bring no significant unmonetised benefits. Academics and think-tanks use reference costs to study healthcare, and they may benefit from a continued time series. However, we know from other organisations using reference costs that they too are concerned about the data's accuracy and consistency. These other users generally support the move to patient-level costs, as they believe it would produce more accurate and granular information, giving them better insights.

Risks of this option

12. Risks and mitigations around this option are shown in Table 3 below.

Table 3: Risks of Option 1

Risk	Mitigation
As this option involves collecting cost data only at average currency level, we expect engagement with costing outside finance functions would be limited.	Options include • Reviewing use and validation of the data as part of the costing assurance programme • Strengthen the expected trust board assurance requirements to include validation of data with medical and other staff
Remaining with reference costs would lose the opportunity to link community data to acute and mental health activity at a national level. This would remove the ability to take advantage of opportunities such as identifying clinical variations among patients and new pathways across sectors not being realised.	An average cost could be used for community services, but this would contrast with patient- level cost data for all other types of provider/service.
There would be a continued lack of consistency without mandation of the standards, leading to differences in how trusts account for costs and activity,	The costing assurance programme could review costing arrangements against the recommended standards

Risk	Mitigation
further undermining the accuracy of costing data.	but there would be issues around enforceability
There is a risk that not mandating patient-level costs would damage NHS England and NHS Improvement's credibility, by undermining the coherence of our approach to costing. We have stated in several publications that mandating patient-level costs is part of our strategy to support the 5YFV, and recently, to support the Long Term Plan.	If this was rejected or timescales change this would show, we are listening to issues from the sector, where capacity for change is limited, and has been further impacted by COVID-19. However as at August 2020 only 2% of trusts (those providing mainly community services that do not have patient- level cost systems) and we have a robust engagement plan, encouraging community providers to be involved in the voluntary collections.

Table 4: Summary of Option 1 costs for NHS community services

Year	1	2	3	4	5	6	7	8	9	10	
Collection year	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**Total**
Financial year	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	
Cost of RC submission	£6,047,609	£6,470,753	£6,767,788	£6,920,429	£7,238,655	£7,571,588	£7,919,910	£8,284,338	£8,665,620	£9,064,538	£74,951,227
Cost - Non community Mandated PLICS	£18,824,188	£17,245,465	£17,965,655	£18,805,205	£19,684,188	£20,604,465	£21,567,986	£22,576,791	£23,633,022	£24,738,918	£205,645,883
Voluntary PLICS	£3,125,219	£2,223,160	£1,546,504	£809,653							
Total cost	**£27,997,015**	**£25,939,378**	**£26,279,946**	**£26,535,287**	**£26,922,843**	**£28,176,053**	**£29,487,896**	**£30,861,130**	**£32,298,642**	**£33,803,455**	£288,301,645
GDP deflator*	1	0.983	0.968	0.953	0.937	0.921	0.904	0.886	0.868	0.849	
Deflated cost	**27,997,015**	**25,498,408**	**25,438,988**	**25,288,129**	**25,226,704**	**25,950,145**	**26,657,058**	**27,342,961**	**28,035,221**	**28,699,134**	266,133,762
Discount rate**	1.000	0.966	0.934	0.902	0.871	0.842	0.813	0.784	0.755	0.726	
PV of Option 1	**27,997,015**	**24,631,462**	**23,760,015**	**22,809,892**	**21,972,459**	**21,850,022**	**21,672,188**	**21,436,881**	**21,166,592**	**20,835,571**	228,132,098

* See Annex 7. ** Discount factor 3.5%.

Option 2

CTP patient-level costs and standards mandated for annual submission from 2021/22 for community activity, and reference costs collected annually for up to two years

Table 5: Estimated cost of Option 2

	Total average annual cost per trust	Total cost over 10 years (see Annex 7)
Option 2	£180,446	£243,939,624

1. Under this option, NHS community providers would have to submit patient-level cost data, complying with the standards, annually from financial year 2021/22 (submitted in 2022). There would be dual running of reference costs for two years, 2021/22 and 2022/23 while we verify that reference costs can be reproduced from patient-level cost data for consistency.

2. As noted in Option 1, we have excluded:

   - E&T from the cost of collection while we work with HEE to assess the impact of E&T data collection for all providers.
   - The cost of any internal financial functions, such as producing service-line reports or budgetary management functions and have only estimated the costs of calculating and providing the reference cost submission. This addresses the differences in how each trust records the time spent on costing and budgetary control-related functions other than producing the mandated cost return.

Assumptions

3. We made the same assumptions as when costing Option 1, plus the following:

   i) All trusts will have PLICS and be ready to comply with the standards for the 2021/22 submission (in 2022).

ii) As compliance with the costing standards and submission of cost data would be required under the NHS Provider licence, any non-compliance could lead to enforcement action.

4. Our costing includes an estimate of costs for acute and mental health providers to submit community costs at a patient level in 2020/21. This has been estimated using the expected time to implement and produce patient-level cost data, adjusted for the size of community services, using data collected from calls and on-site visits, updated for information collected through surveys in 2019 and 2020.

5. As at August 2020, only the 2% of NHS Trusts providing community services have not yet purchased patient-level costing systems (PLICS) – these will have additional revenue costs (software licensing purchase and staffing).[22] We used business case information from other trusts and from on-site meetings to calculate the average cost of implementing a system for those trusts without a costing system.

6. Based on findings from the acute sector and roadmap partners, we used the expected training programme syllabus[23] as the guide for time spent implementing PLICS, updated for feedback from surveys in 2019 and 2020.

7. We have assumed a saving of 20% of time to reflect an estimated time saving from using the same costing standards across both returns based on feedback from other sectors where patient- level costing has been mandated. This reflects the fact that in many areas the same activity data and methods of apportionment would be used for both cost collections. This has been split evenly across reference costs and patient- level costs.

Monetised costs of this option

8. We estimated that the cost of this option would depend on several issues, including each trust's progress towards implementing patient-level costs – those that must purchase and implement PLICS will have additional costs, but only in 2020/21.

[22] There could potentially be some capital costs too (IT infrastructure) but this has not been included.
[23] Available on the NHSI PLICS open learning platform

9. For more details see Table 7.

Costs excluded from analysis of this option

10. We have not included costs for major updates to trusts' financial or patient information systems resulting from implementing PLICS. This may be a more significant concern for the community providers, given the volume of contacts involved which is significantly higher than other sectors. However, there is a lower level of complexity in patient- level costing for community services and there are less systems feeding into the costing process.

Unmonetised benefits of this option

11. As at August 2020, only 2% trusts whose main service was community had implemented PLICS, so at this stage patient-level costing has not been fully implemented and used for community activity. Most of the trusts involved in the early implementer programme or with local versions of patient-level costs are just starting to use benchmark data to identify cost variations. Examples of benefits to date include:

    - Improving the recording of activity information and identification of where information is not recorded or is inconsistently recorded across trusts.
    - Improving the underlying quality of data by sharing cost and activity data with frontline staff and clinicians. This is also improving the underlying information used for planning, reporting activity for internal monitoring, and local contracting.

12. There are a number of expected future benefits that community trusts expect to gain as part of implementing PILCS, many of which are consistent with the benefits which acute trusts have already found. These include.

    - More granular information enables trusts to review unwarranted variation in pathways. This would:
        – Allow better benchmarking, both internally and across the sector, to identify innovative ways of providing services. If all trusts calculated and submitted data in the same way, benchmarking and understanding patient activity and costs would support other initiatives.

  - Producing more consistent cost and activity data between trusts, improving the usefulness of benchmarking and making it easier to compare patient activity and costs.
- Allow community data to be linked with other NHS data which can identify how pathways can be improved across services and providers, key for the moves to an ICS service delivery model.
- Apportion overheads more clearly and consistently and provide a better understanding of cost drivers across the trust.
- Supporting the move to blended payment contracting, with the information underpinning risk by ensuring consistency of counting and costing.
- Identifying where currencies or units of activity need to be reviewed to better reflect the integrated approach to care. Many trusts raised issues that the currency classifications of activity are based on an outdated, unintegrated approach and can hamper more innovative ways of working.

13. Trusts believe many more benefits can be realised in the next few years. Being able to manage an aging population with many more people living with long-term medical condition effectively in the community will reduce the strain on acute services. The NHS Long Term Plan sets out ambitions to 'boost "out-of-hospital" care, and finally dissolve the historic divide between primary and community health services. Being able to link patients across types of providers will improve the outcomes for patients. Another benefit will be the ability to link patient- level cost data to outcome data in the future, which would enable commissioners and trusts to look at how best to use resources available for their population. And the more granular level of information will enable new currencies for community (and other services) to be tested and the impact modelled and better understood.

14. Consistency of costing is important as many of the benefits depend on identifying savings opportunities from accurate benchmarking between and within trusts. Mandation would ensure that all trusts adopt and comply with the new costing standards. This would support other uses of the data, including as the source for planning and agreeing local prices (move to blended payments) and for national cost and activity collections.

15. Consistent collection of cost data would provide significant benefits for regulators. We expect that the quality of data would improve as it will be

easier for trusts to identify errors and correct these before submission. More granular data would be made available via the Model Health System (at a suitably aggregated level), as this becomes the single source of cost and activity data, we expect data collections and requests can be streamlined.

16. A period of dual running would allow providers and NHS England and NHS Improvement to ensure the data submitted is of a good standard. This would allow more time for providers, especially the trusts whose main service is community (the 2% of all trusts which provide community services) to fully implement their system and allow us to introduce an external assurance process, with all submissions reviewed to ensure their accuracy before reference costs cease. However, based on initial feedback from the 2017/18 cost collection for acute trusts and those involved in the voluntary collection in acute and mental health (who submitted patient- level cost and reference cost data) the burden on completing two returns is significant.

Risks of this option

17. There are some specific risks for this option (see Table 6).

Table 6: Risks of Option 2

Risk	Mitigation
As in our other impact assessments of the impact of patient-level costing, we acknowledge the concerns about public perception of the collection and use of patient data.	Although patient-level cost data would be pseudo-anonymised[24], the public may have concerns that would need to be addressed with clear communication and a privacy impact assessment. This is being covered as part of the Information Standard process[25].
By mandating patient-level costs, arrangements for collecting and transferring data will need to comply with Information Standard requirements.[26]	We would continue to work closely with our information governance team. Patients will always have the right to opt out of their

[24] Pseudonymization is a data management and de-identification procedure by which personally identifiable information fields within a data record are replaced by one or more artificial identifiers, or pseudonyms
[25] https://www.england.nhs.uk/tis/
[26] Information Standards (including data collections and extractions) are an agreed set of rules, a consistent method or process for capturing, processing, managing and sharing data and information.

Risk	Mitigation
	details being used for anything other than providing their healthcare.
Where trusts and commissioners use reference costs for agreeing local prices, the move to patient-level costs may bring some uncertainty.	Trusts and commissioners should be moving towards a blended payment approach for services, and patient- level cost supports this by ensuring consistency in counting and coding. Each organisation may need extra time to move towards patient- level cost. and blended payment, but we believe that in future the costs, and therefore the prices, would better reflect patient pathways. We also expect that queries would reduce as better quality information becomes available to commissioners and trusts.
While it would be mandatory to submit patient-level costs using the standards, providers may not comply with the standards.	We expect all trusts to submit patient-level cost data – currently only 2% do not have a CTP-compliant system and we expect them to have implemented one by the time of the first mandatory submission in 2022.
Discussions with providers of community services involved in the early implementation programme indicates that not all trusts will be able to fully comply with the standards from 2021/22.	As with other sectors, we would work with trusts to identify risks to consistent submission, and prioritisation and provide support. This will include a transition pathway for all trusts, including those that are struggling. We would also use benchmarking and analytics to identify concerns and can use enforcement action where necessary as submitting mandated cost information is a condition of the trust licence.
Ability of PLICS system suppliers to support NHS community providers in implementing CTP-compliant PLICS systems. The focus has been on acute providers, with PLICS being mandated there from 2018/19). This has meant that other sectors have been less well supported by costing system suppliers.	The NHS England and NHS Improvements Costing Team has been working with suppliers to ensure systems are in place and the differences between acute and community costing requirements and systems are harmonised. This work would continue for the duration of the CTP programme.

Risk	Mitigation
Ensuring clinicians, executives and board members engage with patient- level cost is key to ensuring it realises all the benefits.	The Costing Team is working with NHS England and NHS Improvement's regional teams to raise the profile of costing for non-finance staff, including clinicians. The quality improvement teams, and operational productivity will use patient-level cost data in use of resources assessments and to identify savings across providers.
Information for contracted-out (outsourced patient activity) work has previously been included in reference costs but has been excluded since 2017/18.	Outsourced activity remains excluded as this is not currently available at a patient level. We are asking trusts to start working with their providers to obtain this at the required level. We will continue to work with the sector as part of the costing transformation programme, with the aim to reduce exclusions from the quantum.

Table 7: Summary of Option 2 costs for NHS community providers

	1	2	3	4	5	6	7	8	9	10	
Collection year	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**Total**
Financial year	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**	
Cost of RC submission	£6,047,609	£6,470,753	£6,767,788								**£19,286,149**
Cost - Non community Mandated PLICS	£18,824,188	£17,245,465	£17,965,655	£18,805,205	£19,684,188	£20,604,465	£21,567,986	£22,576,791	£23,633,022	£24,738,918	**£205,645,883**
Voluntary PLICS	£4,978,258										**£4,978,258**
New system costs	£540,349										**£540,349**
Community mandated PLICS		£6,959,430	£5,993,748	£7,846,118	£8,216,852	£8,605,187	£9,011,963	£9,438,061	£9,884,402	£10,351,953	**£76,307,714**
Total	**£30,390,404**	**£30,675,648**	**£30,727,191**	**£26,651,324**	**£27,901,040**	**£29,209,652**	**£30,579,949**	**£32,014,853**	**£33,517,424**	**£35,090,870**	**£306,758,354**
GDP deflator*	1	0.983	0.968	0.953	0.937	0.921	0.904	0.886	0.868	0.849	
Deflated cost	**£30,390,404**	**£30,154,162**	**£29,743,921**	**£25,398,711**	**£26,143,274**	**£26,902,089**	**£27,644,274**	**£28,365,159**	**£29,093,124**	**£29,792,149**	**£283,627,268**
Discount factor	1.000	0.966	0.934	0.902	0.871	0.842	0.813	0.784	0.755	0.726	
PV of Option 2	**£30,390,404**	**£29,128,920**	**£27,780,822**	**£22,909,638**	**£22,770,792**	**£22,651,559**	**£22,474,795**	**£22,238,285**	**£21,965,309**	**£21,629,100**	**£243,939,624**

* See Annex 7. ** Discount factor 3.5%.

Option 3

Preferred option: Mandate annual submission of patient-level costs for community services from 2021/22, with costing standards mandated. No dual running of reference costs.

Table 8: Estimated cost of Option 3

	Total average annual cost per trust	Total cost over 10 years (see Annex 7)
Option 3	£172,659	£231,676,301

1. Under this option, NHS community providers would have to submit patient-level cost data that complies with the standards annually from financial year 2021/22 (submitted in 2022). There would be no dual running of reference costs, with collection of this data stopping after 2020/21.

2. Due to the lack of national prices for community activity and the impact of dual running of costing systems from those involved in voluntary patient- level cost collections, we believe little would be gained from continuing to collect reference costs at the same time as collecting patient- level cost data. Ceasing the reference cost collection would reduce the burden on trusts, helping them to concentrate on producing accurate and consistent patient-level costs as soon as possible.

3. As noted, we have excluded Education and Training (E&T) from the cost of collection while we work with HEE to assess the impact of E&T data collection on the community sector.

Assumptions

4. We made the same assumptions for this option as when costing Option 2, other than for this option stopping reference cost submission after 2020/21.

Monetised costs of this option

5. As this option is essentially the same as Option 2, excluding dual running, the monetised costs are the same.

6. For more details see Table 10.

Costs excluded from analysis of this option

7. As this option is essentially the same as Option 2, excluding dual running, the same costs have been excluded. Trusts may have some extra costs if their contract arrangements continue to rely on reference cost currencies and this information is no longer be collected nationally. However, trusts could derive this information in the reference cost format from their local patient-level costs and the majority of commissioners and trusts are already moving towards the blended payment model.

Monetised and unmonetised benefits of this option

8. In addition to the benefits noted in Option 2, the burden on trusts of producing the reference cost return would be removed. This was found to be a major issue for acute provided in 2018/19 – with the majority having to run both PLICS (for acute) and reference costs (for all other services) with a reconciliation between the two collections. Ceasing the collection of reference costs would free up time to embed patient-level costing as part of their financial arrangements.

Risks of this option

9. There are some specific risks for this option (see Table 9).

Table 9: Additional risks of option 3

Risk	Mitigation
If the quality of the data produced from patient- level cost was found to be poor or had material issues this could affect local price setting, planning for service redesign and use by other arms-length bodies for research and review	NHS England and NHS Improvement will work with stakeholders to ensure that those using patient- level cost data for contracting or other work are able to access data in a similar format to reference costs (aggregated) and that support will be

Risk	Mitigation
	available (training and guides) on how to use patient- level cost information.
Trusts and commissioners that use reference costs to set local prices for community activity may not have a process for using patient-level cost data to set local prices.	As noted, trusts and commissioners are moving towards a blended payment approach, and patient- level cost underpins this work. We will work with our partners in NHS England to continue to support commissioners and providers in moving towards this payment approach.

10. We have discussed stopping reference costs collection after 2020/21 with NHS community providers and other regulators. Generally, their response to this proposal has been favourable.

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Table 10: Summary of Option 3 costs for NHS Community providers

	1	2	3	4	5	6	7	8	9	10	
Collection year	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**Total**
Financial year	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**	
Cost of RC submission	£6,047,609										**£6,024,476**
Cost - Non community Mandated PLICS	£18,824,188	£17,245,465	£17,965,655	£18,805,205	£19,684,188	£20,604,465	£21,567,986	£22,576,791	£23,633,022	£24,738,918	**£205,645,883**
Voluntary PLICS	£4,978,258										**£4,978,258**
New system costs	£540,349										**£540,349**
Community PLICS		£6,959,430	£5,993,748	£7,846,118	£8,216,852	£8,605,187	£9,011,963	£9,438,061	£9,884,402	£10,351,953	**£76,307,714**
Total	**£30,390,404**	**£24,204,895**	**£23,959,403**	**£26,651,324**	**£27,901,040**	**£29,209,652**	**£30,579,949**	**£32,014,853**	**£33,517,424**	**£35,090,870**	**£293,519,813**
GDP deflator*	1	0.983	0.968	0.953	0.937	0.921	0.904	0.886	0.868	0.849	
Deflated cost	£30,390,404	£23,793,412	£23,192,703	£25,398,711	£26,143,274	£26,902,089	£27,644,274	£28,365,159	£29,093,124	£29,792,149	**£270,715,299**
Discount factor	1.000	0.966	0.934	0.902	0.871	0.842	0.813	0.784	0.755	0.726	
PV of Option 2	**£30,390,404**	**£22,984,436**	**£21,661,984**	**£22,909,638**	**£22,770,792**	**£22,651,559**	**£22,474,795**	**£22,238,285**	**£21,965,309**	**£21,629,100**	**£231,676,301**

* See Annex 7. ** Discount factor 3.5%.

Why we prefer Option 3

1. We believe that Option 3 provides the best value for trusts. Option 1 does not meet our aims of improving the accuracy and consistency of costing and is unlikely to bring sustained benefits. Option 2 achieves the same benefits as Option 3, but we think that dual running with reference costs would impose an unnecessary burden on the sector.

2. In the future we may consider whether collecting data quarterly would be useful to the sector. Our consultation with other sectors found that trusts were in favour of this but that patient-level costs first needed to be embedded in all sectors before we reviewed the frequency of collection and agreed an approach to deal with year-end accounting issues[27].

3. We recommend Option 3 as based on the evidence presented in this report, we believe it will deliver:

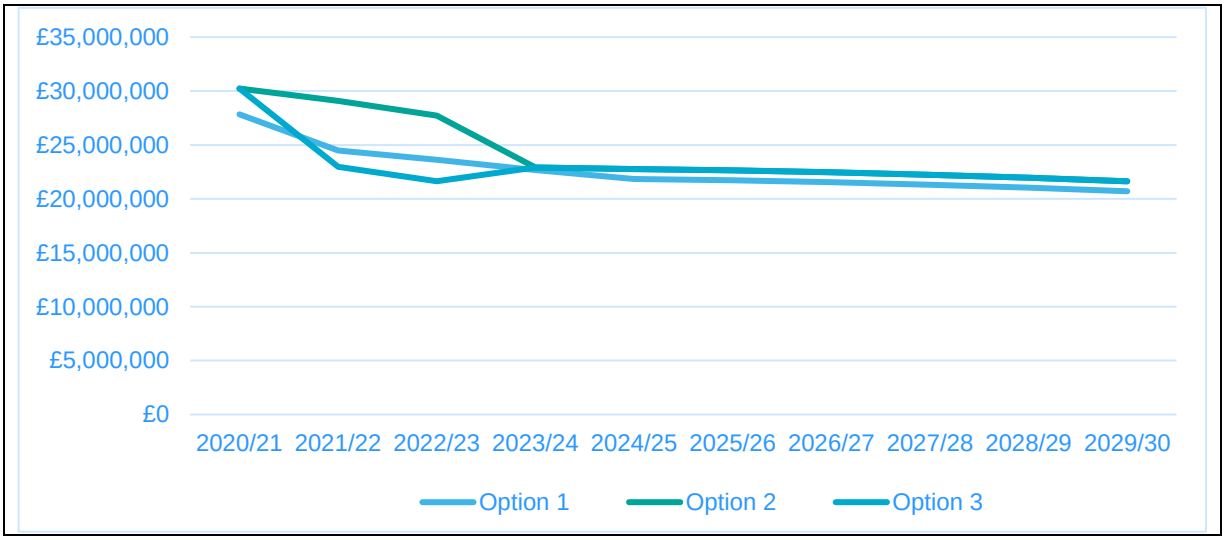
   - consistently collected data to help trusts manage their costs
   - quick identification of variation in activity, pathways and cost against other trusts
   - a contribution to other NHS-wide efficiency objectives, such as NHS England and NHS Improvement's operational productivity work, as more consistent data would enable central provision of more accurate and timely information to support trusts in managing their costs
   - more accurate activity and financial data for trusts; services and clinicians would validate the data, so issues could be identified and corrected – this would help improve internal forecasting and financial management
   - the commissioning process and patient-level cost data could eventually reduce the data requested by commissioners and regulators.

[27] For 2020/21 a voluntary quarterly cost collection (called the Exceptional Quarterly Collection) is in place. A sample of acute trusts are providing their own costing data on a quarterly basis to provide NHS England and NHS Improvement with information on the impact of COVID-19 on patient pathways and costs.

4. Although Option 2 would bring similar benefits, Option 3 would reduce the burden on providers' small finance teams and allow trusts to focus on patient-level costs as the primary source of costing data.

5. Our cost analysis indicates that over the next ten years producing reference costs would provide significantly less benefits than patient- level costs. This is because we believe (and have seen in the acute sector) patient- level costing will become embedded in trusts, and that it will support service line reporting and the development of business cases. It will also, to some extent, be more automated than reference costs. We also believe that many trusts will use the same methods for costing services that are let on a commercial basis.

Figure 2: Total cost of all options by year, expressed in terms of present value



6. The costs of the three options diverge over the period of the review:

   - Option 1 is initially cheaper in 2020/21 (excluding the voluntary collection of PLICS for years 2 to 5) but is then fairly static for the rest of the period under review. Given the limited costing resources in most trusts feedback indicates that where something is not mandated, less importance is attached to producing and validating it. Therefore, we expect that, without an expectation to mandate, trusts would focus on submitting reference costs and other day-to-day demands rather than patient-level costs, and that this choice would not change the cost or costing significantly for their trust.

- The costs of Option 2 are higher than those of Option 1 in the first three years, due to dual running and mandation of both reference costs and patient-level costs. By 2023/24, we expect that the costs of Option 2 would be the same as Option 3.
- Option 3 is cheaper than Option 2 in the first two years because there is no dual running, and costs are similar thereafter. However, as already noted, removing dual running would allow the sector to focus on implementing patient-level costs without increasing the burden on trusts, especially on non-acute trusts which tend to have very small finance teams.

7. The proposal to move straight to patient-level costs with no dual running has been discussed with other data users (including the NHS England and NHS Improvement's operational productivity and finance directorates, the Community Technical Focus Group and other users of the data. They support the proposal not to have dual running because it reduces the burden on trusts and supports the successful implementation of patient-level costs.

Plan for monitoring and evaluation

1. Our evaluation of the impact (in terms of both costs and benefits) of patient-level costing once it is implemented is important, especially as this is the last sector to have PLICS mandated. We planned to verify the findings from implementing patient-level costing for all providers and the assumptions in the various impact assessments. However, this has been rescheduled for 2021, due to the impact of COVID-19 and the voluntary collection of quarterly cost information from a sample of providers to identify the impact of the pandemic on acute services (the Exceptional Quarterly Collection[28])

2. We will introduce methods to evaluate the impact and use our findings to inform the impact assessment for other sectors. We will:

    - survey all providers in 2021 to:
        - validate the staff and system resources needed for the voluntary patient-level costs and reference costs submissions
        - identify any new issues
    - work with the national cost collections team to validate the assumptions used
    - review the outcome of the pricing engagement team's project to publish innovative uses of patient-level cost data across various sectors; we will assess whether the benefits to trusts outweigh the costs.

3. We will use the findings from all this work to validate or update the assumptions in this impact assessment to ensure they remain reasonable for any future plans around increasing the regularity of submission or extending to independent sector providers.

[28] https://www.openlearning.com/nhs/

4. As part of the CTP we are - and will continue to - monitor the impact and output from trusts as part of our ongoing work around costing. We will respond accordingly where any additional unintended impacts are identified.

Annex 1: Monitor's statutory duties

1. This annex explains how the discharge of Monitor's[29] 'general duties' would be secured by implementing the proposals relating to patient-level costs, as required by section 69(5) of the Health and Social Care Act 2012 (the 2012 Act). Monitor's general duties are those set out in Sections 62 and 66 of the Act, which Monitor must discharge when exercising its functions, including its pricing functions. These general duties require Monitor to have regard to certain matters when exercising those functions or acting with a view to achieving objectives.

2. The 2012 Act also provides that Monitor should state why the duties would not be secured by the exercise of Monitor's statutory functions under the Competition Act 1998 and Part 4 of the Enterprise Act 2002. Our view is that the exercise of those functions relating to competition would not enable NHS England and NHS Improvement to implement detailed changes to the requirements on NHS Trusts as to how they record and report the cost of community services, so as to deliver the benefits involved in patient-level costing (either for local prices or for the individual trusts concerned) and so would not secure the discharge of Monitor's general duties in relation to the arrangements for the costing of NHS services.

3. The table below sets out each of the duties and explains:

   - how implementing the proposals would secure the discharge of that duty
   - where appropriate, how NHS England and NHS Improvement has complied with the duty in developing and making these proposals.

4. In addition to the 2012 Act general duties, the summary below also explains certain other duties that apply to the exercise of Monitor's functions, including the public sector equality duty.

[29] This reference to regulatory action by NHS Improvement refers to the use of the powers of either Monitor or the NHS Trust Development Authority, depending on the trust in question.

Section and subject	Requirement	How addressed
Section 62(1)(a) Economy, efficiency and effectiveness	Monitor's main duty in exercising its functions is to protect and promote the interests of people who use healthcare services by promoting provision of healthcare services which (a) **is economic, efficient and effective**, and (b) maintains or improves the quality of the services. In carrying out this duty, Monitor must have regard to the likely future demand for healthcare services.	Introducing patient-level costing using consistent methods for calculating costs would enable NHS community providers to benchmark the various aspects of patient pathways to identify improvements in interventions and services. Future links with outcome data would allow NHS community providers to work with other providers to identify where service provision for patients can be improved. It would also improve the accuracy and granularity of the costing data available to trusts and commissioners when agreeing local tariffs. This would improve the setting of prices, enabling them to better reflect efficient costs. Understanding the cost of patient care would help trusts to improve the efficiency of their services. In relation to the future demand for healthcare services, patient-level costs would help trusts understand their costs and the impact of any proposed changes. It can also support trusts to better understand the services delivered across geographical areas and different trusts. Understanding patient pathways and costs across all types of providers would support service reconfiguration by eventually providing more granular and consistent information across all sectors.

Section and subject	Requirement	How addressed
Sections 62) (1)(b), 66(1) and (2)(a) **Safety and quality**	Monitor's main duty in exercising its functions is to protect and promote the interests of people who use healthcare services by promoting provision of healthcare services which is (a) economic, efficient and effective, and (b) **maintains or improves the quality of the services**. In carrying out this duty, Monitor must have regard to the likely future demand for healthcare services. Monitor must have regard, in particular, to the need to maintain the safety of people who use healthcare services. Monitor must have regard to the desirability of securing continuous improvement in the quality of NHS healthcare services and in the efficiency of their provision (so far as they are consistent with the need to maintain safety of people who use healthcare services).	As noted above, patient-level costing would allow trusts to identify and address unwarranted pathway variation and improve the accuracy of underlying data – both cost and activity, as early implementing trusts are already finding. Plans to link patient-level cost data to clinical outcomes across all sectors, including community, would enable trusts and commissioners to: • identify where patient pathways can be improved • ensure resources are used to maximum benefit • support discussion on innovative delivery of services. Patient-level costs provide greater granularity and consistency in costing and pathway information. This would lead to local prices that better reflects actual costs, supporting the move to a blended payment approach, which in turn would support financial sustainability of trusts. More granular information would enable trusts to make better-informed decisions on service provision and patient care, and – by linking to outcome data – would support continuous improvement.
Section 62(3) **Competition**	Monitor must exercise its functions with a view to preventing anti-competitive behaviour in the provision of NHS healthcare services that is against the interests of people who use such services.	We consider that the proposals would not facilitate anti-competitive behaviour.

Section and subject	Requirement	How addressed
Section 62(4), (5) and (6) and 66(2)(e) **Integration and co-operation**	Monitor must exercise its functions with a view to enabling NHS healthcare services to be provided in an integrated way and the integration of NHS and social care or other health-related services where it considers that this would: • improve the quality of services or the efficiency of their provision • reduce inequalities with respect to access or outcomes. Monitor must, in carrying out its duties relating to integration above, have regard to the way in which NHS England and clinical commissioning groups (CCGs) carry out their duties to promote integration. Monitor must (so far as they are consistent with the need to maintain safety of people who use healthcare services) have regard to the desirability of persons who provide NHS healthcare services co-operating with each other to improve the quality of those services.	By providing consistent information across organisations and across the patient pathway, patient-level costs would support the delivery of services across providers as the method of costing would be consistent regardless of the provider and should also support innovation in the provision of services, regardless of the setting. Patient-level costing across all sectors, including community, would support the delivery of care across the new care models, including accountable care organisations (ACOs), sustainability and transformation partnerships (STPs) and Integrated Care Systems (ICS).
Section 62(7) **Patient and public involvement**	Monitor must secure that patients and other members of the public are involved to an appropriate degree in decisions that Monitor makes about the exercise of its functions.	We consider that the proposals do not require patient or public involvement. Mandating patient-level costs would improve the calculation of local prices. Being able to link to clinical outcomes would enable providers, commissioners and regulators to show how future service redesign would provide a better service to patients. It will also support the move to a blended payment model and support work around risk share agreements.

Section and subject	Requirement	How addressed
Section 62(8) **Clinical and public health advice**	Monitor must obtain appropriate professional clinical and public health advice to enable it to discharge its functions effectively.	We consider that appropriate clinical advice has and continues to be received through our work with clinicians on projects including Get It Right First Time (GIRFT) and various Royal College Expert Working Groups as part of our working arrangements. We do not believe that specific public health advice is required as the mandation relates to community services.
Section 62(9) **Comprehensive health service**	Monitor must exercise its functions in a manner consistent with the Secretary of State's duty to promote a comprehensive health service.	The patient-level cost proposals are consistent with the discharge by the Secretary of State of his duty to continue the promotion of a comprehensive health service, which is designed to secure the improvement in the prevention, diagnosis and treatment of physical and other illness. In particular, the proposals ensure progress towards the effective implementation of the NHS Long Term Plan. The provision of more accurate data at a patient level, which would be linked to outcome, would support trusts to identify improvements in pathways. It would identify where improvements to services can be made locally and ensure national decisions are made on the most accurate data available.
Section 62(10) **Fair playing field**	Monitor must not exercise its functions for the purpose of causing a variation in the proportion of NHS healthcare services that is provided by persons of a particular description if that description is by reference to whether the persons in question are in the public or (as the case may be) private sector.	The proposals support the main objective in the 2019/20 mandate to ensure progress towards the effective implementation delivery of the Long Term Plan. It specifically supports: Future links to clinical outcomes would support service redesign by identifying where patients could have been more appropriately treated.

Section and subject	Requirement	How addressed
		In line with the current cost arrangements (reference costs), the proposal would not include collection of cost data from independent sector trusts. This should not itself cause a variation in the proportion of services carried out by that sector. Local prices, set on the basis of costing data, would continue to apply across all providers. We continue to work with the independent sector to investigate the possibility of extending collection to their costs.
Section 66(2)(b) to (d) **Duties of commissioners**	Monitor must (so far as it is consistent with the need to maintain safety of people who use healthcare services) have regard to the need for NHS commissioners to: • ensure that the provision of access to NHS services operates fairly • ensure that people who require NHS healthcare services are provided with access to them • make the best use of resources when doing so.	We anticipate that the collection of patient-level cost data would provide more accurate information for pricing. This would: • provide better and more transparent local information on costs that are the basis for local prices agreed by commissioners and trusts • support trusts and commissioners when looking to implement and fund the move to a blended payments approach to funding.
Section 66(2)(f) Research	Monitor must (so far as is consistent with the need to maintain safety of people who use healthcare services) have regard to the need to promote research into matters relevant to the NHS by persons who provide NHS healthcare services.	We consider that the proposals would have no adverse effect on research in NHS community providers.

Section and subject	Requirement	How addressed
Section 66(2)(g) Education and training	Monitor must (so far as it is consistent with the need to maintain safety of people who use healthcare services) have regard to the need for high standards in the education and training of healthcare professionals who provide NHS healthcare services.	The proposals do not include any specific changes that actively promote education and training (E&T). As with reference costs collections, we are reviewing the arrangements for future E&T collection of education and training data as part of the patient-level cost data collection.
	Other general statutory duties	
Section 116(13) of the 2012 Act **NHS England's mandate**	When exercising its pricing functions Monitor must have regard to the objectives and requirements in the government's mandate to NHS England.	The proposals support the main objective in the 2019/20 mandate to ensure the effective delivery of the Long Term Plan. It specifically supports: • Objective 1a): Laying the foundations for successful implementation of the Long Term Plan • Objective 1b): Achieving financial balance and • Objective 1c) : Maintaining and improving performance, and improving the quality and safety of services
Section 1 of the Health Act 1999 **NHS Constitution**	Monitor must have regard to the principles, values, rights and commitments of the NHS Constitution.	We consider that the proposals support the seven key principles that guide the NHS in all it does, including: • supporting access regardless of ability to pay • enabling clinicians to identify and aspire to the highest standards and excellence • putting the patient at the heart of information – both clinically and financially

Section and subject	Requirement	How addressed
		• supporting accountability by ensuring consistency of costing and recording of patient pathways. By facilitating a better understanding of the costs of treatment and helping trusts to remove unwarranted variations and making other improvements, they would also assist NHS bodies in delivering services in accordance with the rights of patients set out in the Constitution, such as the rights relating to access to health services and the quality of care and striving to reduce the health gap between people with health problems being managed in a community setting, with long term chronic conditions and the population as a whole, and support them to live full, healthy and independent lives.
Section 149 of the Equality Act 2010 Public sector equality duty	Both Monitor and the NHS Trust Development Authority, the constituent bodies of NHS Improvement, have a duty under the Equality Act 2010 (the public sector equality duty) to have regard to equality issues as set out in the Act when developing policy proposals. Protected characteristics under the Equality Act include age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.	Our view is that the proposals would not have any differential impact on any group of patients with protected characteristics, when compared with other patients. The benefits brought by patient-level costs would assist all types of patients who receive NHS community services, including those with protected characteristics. The granularity of data, which in future can be linked across providers and to outcome information, will enable commissioners and providers to better target resources to support those living in the community with health issues. More accurate data will lead to system-wide transformation of services, with a greater focus on prevention, early intervention and support.

Annex 2: Initial options appraisal list

	Description 2020/21 onwards	Benefits	Disadvantages	Decision for impact assessment
A	**The 'do nothing' scenario:** Reference costs (RC) collected annually and patient- level cost collected annually on a voluntary comply-or-explain basis	1. What we have now – no further investment required for those without CTP patient-level costs	1. Does not provide information to support ACS/ICS 2. Seen as costing-only exercise 3. Only provides average costs	Included – Needs to be included in impact assessment as no-change option
B	**Mandating RC standards:** RC collected annually with use of standards mandated. patient-level cost remain a voluntary annual collection	1. What we have now 2. Mandation of standards (including costing approaches and methodologies) would improve consistency of data submitted for RC	1. Does not provide information to support ACS/ICS 2. Seen as costing-only exercise 3. Only provides average costs	Excluded as does not provide sufficient clinical or granular data
C	**Mandating annual patient-level costs with dual running of RC for two years:** patient-level cost and standards mandated for annual submission from 2020/21 for NHS community activity, with dual running of RC for the next two years	1. Mandation of standards (including costing approaches and methodologies) would improve consistency of data submitted for RC 2. Reduce the burden on trusts by removing reference costs collection	1. No fall-back position if issues found with quality of patient-level cost submissions	Include in impact assessment
D	**Mandating annual patient-level cost without dual running:** patient- level cost and	1. Longer-term implementation would enable all trusts to ensure quality of patient-level cost data while having RC	1. Would be burden on trusts as they would need to run both systems for two-plus years.	Included – would allow focus on patient- level cost

	Description 2020/21 onwards	Benefits	Disadvantages	Decision for impact assessment
	standards mandated on an annual basis for all NHS community providers, and RC ended after 2019/20 for community activity	available as fall-back position 2. Would promote consistency with both RC and patient-level costs submitted using agreed standards 3. Allow time for NHS Improvement and NHS Digital to address and improve any submission/collection issues 4. This is nearest to BDO report from 2013 which was basis for initial consultation for move to patient-level costs	2. Burden on NHS Improvement in collecting and validating both patient-level costs and RC accuracy – especially if not using RC for tariff in future years 3. Dilute importance of patient-level costs with RC still running	implementation and reduce burden on trust finance staff
E	**Mandating quarterly collection of patient-level costs:** patient- level cost and standards mandated for annual submission from 2020/21 for NHS community activity, moving to quarterly/monthly for 2023/24, and RC collected annually for the following two years (ending in 2019/20)	1. Longer-term implementation would enable all trusts to ensure quality of patient-level cost data while having RC available as fall-back position 2. Would promote consistency with both RC and patient-level costs using agreed standards 3. Allow time for NHS Improvement and NHS Digital to address and improve any submission/collection issues 4. This is nearest to BDO report from 2013 which was basis for initial consultation for move to patient-level costs	1. Would be burden on trusts as would need to run both systems for two-plus years. 2. Burden on NHS Improvement in collecting and validating both patient-level costs and RC accuracy – especially if not using RC for tariff in future years 3. Dilute importance of patient-level costs with RC still running	Excluded based on feedback from acute sector. To be considered in the future
F	**Mandating RC standards from 2020/21 and mandating**	1. Longer-term implementation would enable all trusts to ensure quality of	1. Would be burden on trusts as would need to run both systems	Excluded as splitting standards from

	Description 2020/21 onwards	Benefits	Disadvantages	Decision for impact assessment
	patient- level cost from 2021/22: Standards mandated for 2020/21 for annual RC submission and CTP patient-level cost annual submission, with mandation of CTP patient-level cost from 2021/22 and RC ending in 2020/21	patient-level cost data while having RC available as fall-back position 2. Would promote consistency with both RC and patient-level costs submitted in 2018/19 using agreed standards 3. Allow time for NHS Improvement and NHS Digital to address and improve any submission/collection issues	for two-plus years. 2. Burden on NHS Improvement in collecting and validating both patient-level costs and RC accuracy – especially if not using RC for tariff in future years 3. Dilute importance of patient-level costs with RC still running	patient-level cost mandation is seen as undermining improvement aim.

	Description 2020/21 onwards	Benefits	Disadvantages	Decision for impact assessment
G	**Phased mandation of patient-level cost and standards:** The early implementers in 2020/21 and the remaining trusts in 2021/22, with RC collected for all community activity until patient- level cost is implemented	1. Longer-term implementation would enable all trusts to ensure quality of patient-level cost data while having RC available as fall-back position 2. Would allow NHS Improvement to provide targeted support to trusts requiring more time/support to move to CTP patient-level costs 3. Allow time for NHS Improvement and NHS Digital to address and improve any submission/collection issues 4. Gives more time for other data users to update systems, etc to be able to use data while having back-up of RC if issues found 5. Would allow all trusts to be audited once with full follow-up to ensure data is of a sufficient standard	1. There would be the burden over two to three years of producing both RC and patient-level cost data 2. Impact on NHS Improvement and NHS Digital of running two collection processes and verification costs 3. Would need to assess impact of more regular submissions on both trusts and data users 4. This is a new option not flagged before, and splitting sector would be seen as an issue for other data users (especially Carter/ Model Hospital) 5. This would be hard to manage and there would be issues around how the phasing would work and who would be on what phase	Excluded – felt too confusing to manage and undermines moving sector as a whole.

	Description 2020/21 onwards	Benefits	Disadvantages	Decision for impact assessment
H	**Phased mandation of patient-level cost and standards with dual running of RC and moving to quarterly collection after two years:** The early implementers in 2020/21 and the remaining trusts in 2021/22, with RC collected until patient-level cost is implemented, then moving to quarterly submission two years later	1. Longer-term implementation would enable all trusts to ensure quality of patient-level cost data while having RC available as fall-back position 2. Would allow NHS Improvement to provide targeted support to trusts requiring more time/support to move to CTP patient-level costs 3. Allow time for NHS Improvement and NHS Digital to address and improve any submission/collection issues 4. Gives more time for other data users to update systems, etc to be able to use data while having back-up of RC if issues found 5. Signposting the timetable for NHS community providers to allow them to move towards more regular patient-level cost submission, with detailed timetable at a trust level 6. Would allow all trusts to be audited once with full follow-up to ensure data is of sufficient standard	1. There would be the burden over two to three years of producing both RC and patient-level cost data 2. Impact on NHS Improvement and NHS Digital of running two collection processes and verification costs 3. Would need to assess impact of more regular submissions on both trusts and data users 4. This is a new option not flagged before, and splitting sector would be seen as an issue for other users of data (especially Carter/Model Hospital) 5. This would be hard to manage and there would be issues around how the phasing would work and who would be on what phase	Excluded – felt too confusing to manage and undermines moving sector as a whole.

Annex 3: Trusts covered by the mandation

1. There are 180 trusts that provide community services covered by this mandation (at 2017/18). Of these:[30]

   - 132 acute trusts that also provide community services
   - 22 mental health trusts that also provide acute and community services
   - 5 mental health trusts that provide community services
   - 10 community trusts that also provide acute and mental health services and
   - 11 community trusts that also have acute services.

2. We have used the 2017/18 reference costs submission to identify each trust's main service and, from this, when we expect they would be required to submit patient-level costs for each type of service (acute, mental health, community or ambulance[31]).

3. Assuming mandation is approved for all sectors, we have produced a timetable to identify when we would expect trusts that provide community services covered by this mandation to start submitting patient level data.

4. In our impact assessment we have included an estimate of costs for trusts that provide community services, but these are not their main service provision.

[30] Taken from the 2017/18 reference cost submissions.
[31] Subject to impact assessments and the consultation process for mental health and community services.

Annex 4: Survey results

1. Over the course of the impact assessment, two main surveys were undertaken – one in the summer of 2019 and an updated survey in summer of 2020.

Table 11: Trusts responding to surveys

Type of trust	2019	2020
Acute providers with community services	3	5
Mental Health providers with community services	1	6
Community providers with acute services	1	6
Total	**5**	**17**

Risk areas

2. We asked whether the trust had any areas for which it did not think it could produce the required level of data. The consistent concern was around data quality, especially collecting and validating the data. This was mostly raised around the lack of recording of start and finish times for contacts and was consistent across both surveys. Other key issues noted included:

   i) The cost of implementing patient- level cost for community services – but most agreed that this was vital to support the move to system costing

   ii) The impact of the pandemic in 2020 is a key concern – however again, many trusts saw the benefits of better data to support provision of services in the community and also to improve engagement with teams in planning services

   iii) A small number of trusts raised issues around use of different patient record systems in community and the burden that may place on staff producing the submissions.

Annex 5: Trusts and other organisations involved in impact assessment

Trusts contacted directly

Org code	Trust
RXR	East Lancashire Hospitals NHS Trust
RFR	The Rotherham NHS Foundation Trust
RKE	The Whittington Hospital NHS Trust
RRK	University Hospitals Birmingham NHS Foundation Trust
RCF	Airedale NHS Foundation Trust
RY3	Norfolk Community Health and Care NHS Trust
TAD	Bradford District Care NHS Foundation Trust
RHA	Nottinghamshire Healthcare NHS Foundation Trust

Members of the Community Technical Focus Group

Org code	Trust
RYW	Birmingham Community Healthcare NHS Foundation Trust
RXQ	Buckinghamshire Healthcare NHS Trust
RWY	Calderdale & Huddersfield NHS Foundation Trust
RV3	Central and North West London NHS Foundation Trust
RYX	Central London Community Healthcare NHS Trust
RYG	Coventry and Warwickshire Partnership NHS Trust
RY8	Derbyshire Community Health Services NHS Foundation Trust
RXM	Derbyshire Healthcare NHS Foundation Trust

RNA	Dudley group of hospitals
R1J	Gloucestershire Care Services NHS Trust
RY4	Hertfordshire Community NHS Trust
RYY	Kent Community Health NHS Foundation Trust
RW5	Lancashire Care NHS Foundation Trust
RT5	Leicestershire Partnership NHS Trust
RY5	Lincolnshire Community Health Services NHS Trust
RRE	Midlands Partnership NHS Foundation Trust
RNL	North Cumbria University Hospitals NHS Trust
RAT	North East London NHS Foundation Trust
RTV	North West Boroughs Healthcare NHS Foundation Trust
RHA	Nottinghamshire Healthcare NHS Foundation Trust
R1D	Shropshire Community Health NHS Trust
RJC	South Warwickshire NHS Foundation Trust
RW1	Southern Health NHS Foundation Trust
RDR	Sussex Community NHS Foundation Trust
RDR	Sussex Community NHS Foundation Trust
RMP	Tameside and Glossop Integrated Care NHS Foundation Trust

Trusts responding to survey 2019

Org code	Trust
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust
RWF	Maidstone And Tunbridge Wells NHS Trust
RKL	West London NHS Trust
RRK	University Hospitals Birmingham NHS Foundation Trust
RYY	Kent Community Health NHS Foundation Trust (Incomplete)

Trusts responding to survey 2020

Org code	Trust
RBS	Alder Hey Children's Hospital
RYX	Central London Community Healthcare NHS Trust
RJ8	Cornwall Partnership NHS Foundation Trust
RXP	County Durham & Darlington NHS Foundation Trust
RY8	Derbyshire Community Health Services NHS Trust
RDE	East Suffolk and North Essex NHS Foundation Trust
RV9	Humber NHS Foundation Teaching Trust
RY5	Lincolnshire Community Health Services
RW4	Mersey Care NHS Foundation Trust
RXF	Mid Yorkshire Hospitals NHS Trust
RRE	Midlands Partnership NHS Foundation Trust
RTV	North West Boroughs Healthcare NHS Foundation Trust
REF	Royal Cornwall Hospital Trust
RDR	Sussex Community NHS Foundation Trust
RA7	University Hospitals Bristol and Weston NHS Foundation Trust
RY7	Wirral Community Health & Care
RDR	Sussex Community

Other organisations

Organisation	Organisation
Operation Productivity – NHS Improvement	NHS England pricing development team
National Audit office	Pricing – NHS Improvement
Model Health Team	

Annex 6: Adjusting costs for inflation

1. The cost information in the detailed costing tables (numbers re based on the base year of 2019/20 (2020 costing submission). The costs have been adjusted to reflect the expected increase in the contract costs over the period due to extra cost of IT systems and staffing costs. This adjustment is additional to that for inflation and gives the nominal value of expected costs over 10 years. In this annex, these costs have been adjusted by the GDP deflator forecasts, using 2019/20 as the base year. This removes the effect of general inflation and allows comparison of costs in different years.

2. The costs for the annex table should be multiplied by the column in yellow in the attached spreadsheet. The green book gives the following example of how to display this.

Table 1. Adjusting for the Effects of Inflation (Using a 2% GDP Deflator)

Year	0	1	2	3	4	5
Nominal terms	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000
Real terms (year 0 prices)	£1,000	£980	£961	£942	£924	£906

3. The sum (called the GDP rate in the table) has then been multiplied to give the present value (PV). This is the GDP deflated value with future costs (or benefits) discounted using a discount factor of 3.5% as recommended by HM Treasure (Green book[32]).

32 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/685903/The_Green_Book.pdf

Annex 7: Trusts covered by the proposal

Trusts covered by community health mandation from 2021/22

Org code	Trust
RCF	AIREDALE NHS FOUNDATION TRUST
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST
RF4	BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST
RRP	BARNET ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST
R1H	BARTS HEALTH NHS TRUST
RC1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST
RYW	BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
TAJ	BLACK COUNTRY HEALTHCARE NHS FOUNDATION TRUST
RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST
RMC	BOLTON NHS FOUNDATION TRUST
TAD	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
RY2	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST

RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST
RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST
RV3	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST
RYX	CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
RXA	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST
RJ6	CROYDON HEALTH SERVICES NHS TRUST
RN7	DARTFORD AND GRAVESHAM NHS TRUST
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST
RP5	DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST
RJN	EAST CHESHIRE NHS TRUST
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
RXR	EAST LANCASHIRE HOSPITALS NHS TRUST
RWK	EAST LONDON NHS FOUNDATION TRUST
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST

RXC	EAST SUSSEX HEALTHCARE NHS TRUST
RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST
R1L	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST
RLT	GEORGE ELIOT HOSPITAL NHS TRUST
RTQ	GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST (RTQ)
RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST
RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST
RY4	HERTFORDSHIRE COMMUNITY NHS TRUST
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
RY9	HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST
RWA	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
RV9	HUMBER TEACHING NHS FOUNDATION TRUST
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST
R1F	ISLE OF WIGHT NHS TRUST
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
RYY	KENT COMMUNITY HEALTH NHS FOUNDATION TRUST
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST
RW5	LANCASHIRE CARE NHS FOUNDATION TRUST
RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

RY6	LEEDS COMMUNITY HEALTHCARE NHS TRUST
RR8	LEEDS TEACHING HOSPITALS NHS TRUST
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST
RJ2	LEWISHAM AND GREENWICH NHS TRUST
RY5	LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
R1K	LONDON NORTH WEST HEALTHCARE NHS TRUST
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST
RPA	MEDWAY NHS FOUNDATION TRUST
RW4	MERSEY CARE NHS FOUNDATION TRUST (a)
RDD	MID AND SOUTH ESSEX NHS FOUNDATION TRUST
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
RXF	MID YORKSHIRE HOSPITALS NHS TRUST
RRE	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
RY3	NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST
RVJ	NORTH BRISTOL NHS TRUST
RNN	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST
RAT	NORTH EAST LONDON NHS FOUNDATION TRUST
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST
RTV	NORTH WEST BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST
RJL	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST
RNU	OXFORD HEALTH NHS FOUNDATION TRUST
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
RPG	OXLEAS NHS FOUNDATION TRUST
RW6	PENNINE ACUTE HOSPITALS NHS TRUST
RT2	PENNINE CARE NHS FOUNDATION TRUST
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST
RHU	PORTSMOUTH HOSPITALS NHS TRUST
RXE	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST
REF	ROYAL CORNWALL HOSPITALS NHS TRUST
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
RM3	SALFORD ROYAL NHS FOUNDATION TRUST
RNZ	SALISBURY NHS FOUNDATION TRUST
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST
R1C	SOLENT NHS TRUST
RH5	SOMERSET NHS FOUNDATION TRUST
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST
R0B	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST (R0B)
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST
RJ7	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
RBN	ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST
RWJ	STOCKPORT NHS FOUNDATION TRUST
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST
RDR	SUSSEX COMMUNITY NHS FOUNDATION TRUST
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST
RCX	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST
RFR	THE ROTHERHAM NHS FOUNDATION TRUST
RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST
RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST
RKE	THE WHITTINGTON HOSPITAL NHS TRUST
RA9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
RA7	UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST (UHBW)
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
RBK	WALSALL HEALTHCARE NHS TRUST
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST
RKL	WEST LONDON MENTAL HEALTH NHS TRUST
RGR	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
RA3	WIRRAL COMMUNITY NHS FOUNDATION TRUST
RY7	WIRRAL COMMUNITY NHS TRUST
RBL	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
R1A	WRIGHTINGTON WIGAN AND LEIGH NHS FOUNDATION TRUST
RRF	WYE VALLEY NHS TRUST
RLQ	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
RA4	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST

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