NHS

Feedback from consultation on mandating patient-level costing for the Community sector

March 2021

This guidance is correct at the time of publishing. However, as it is subject to updates, please use the hyperlinks to confirm the information you are disseminating to the public is accurate.

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1. Introduction

1. Between December 2020 and January 2021, NHS England and NHS Improvement consulted on proposals to mandate NHS Foundation Trusts and NHS Trusts to record and report the costs of community services activity at a patient level. See Section 5 for details of the trusts covered by the mandation.

2. Information about the consultation was published on the NHS England website, on the Open Learning Platform for NHS trusts, and in Costing and Provider Newsletters. Trusts were able to complete the online survey on the Open Learning Platform; other non-NHS Trusts and organisations were able to respond via the NHS England and NHS Improvement mailbox.

3. We received 39 responses from five types of organisation:

NHS community provider	NHS integrated provider	Other NHS	Other Non-NHS	External organisations	Total
9 (47% of community-only providers)	26 (17% of integrated providers)	1	2	1	39[1]

4. The consultation asked for views on two proposals:

- **Proposal 1** – To what extent do you agree with mandating patient-level data for community health services at a patient level in line with the methodologies and approaches in the Healthcare Costing Standards for England, from 2021/22?
- **Proposal 2** – Do you agree with the proposal to cease collection of reference costs for community activity from 2020/21?

5. In response to the consultation:

- 23 trusts (66% of respondents) agreed with making recording and reporting of patient-level cost data for community health activity mandatory from

[1] The 35 Trusts equates to 20.6% of all trusts affected, which is mid-way between the percentage of trusts who responded to the mental health consultation in 2019/20 (24%) and the 43% wo responded to the acute mandation consultation in 2017.

2021/22. The key benefits highlighted included: consistency of costing across organisations, the ability to benchmark costs and the ability to link to acute providers, thus improving the accuracy and completeness of patient data.
- 25 trusts (71%) agreed with ceasing collection of reference costs from 2020/21 – those in favour believe that this would reduce some of the burden whilst also improving engagement in their organisations with PLICS.

6. Of the four other respondents:

- 3 participants (75% of non-NHS Trust respondents) agreed with making recording and reporting of patient-level cost data for community health activity mandatory from 2021/22. The other respondent neither agreed not disagreed.
- 2 participants (50%) agreed with ceasing collection of reference costs from 2020/21. One did not answer, and one did not agree.

7. After considering the consultation results, the impact assessment and the mandation project, NHS England and NHS Improvement has decided to implement the proposals to mandate the collection of patient-level costs for community health services from 2021/22.

8. All NHS Trusts and NHS Foundation Trusts which provide community health services (whether it is the trust's main service or not) will be mandated to record and report costs at a patient level, consistent with the relevant costing standards from 2021/22. The following services will remain collected via workbook until such time as underlying collection issues/currencies are agreed:

- Cancer Multi-Disciplinary Team Meetings
- Community midwifery, home births and maternity ultrasound scans
- Chemotherapy and Radiotherapy
- Rehabilitation
- Specialist Palliative care
- Renal Dialysis
- Wheelchair services
- Directly Accessed Diagnostic and Pathology Services.

9. Section 3 of this document summarises the feedback we received from the consultation and our responses to it.

10. In Section 4, we have included the responses to the additional question included in the consultation on the future direction of travel for costing in this sector. This has been provided for information only.

11. We would like to thank everyone who responded, especially in providing information around the future option to increase the frequency of collections. We will take this into account in any future review on the frequency of cost collections.

12. We are also working with colleagues in NHS Digital to move to a single collection of the national cost data as soon as possible, with the aim of reducing the burden of cost collections on colleagues in trusts.

2. Consultation feedback

Response	To what extent do you agree with mandating patient-level data for community services in line with the methodologies and approaches in the Healthcare Costing Standards for England, from 2021/22	
	Number	%
Agree strongly	1	3%
Agree	25	64%
Neither agree nor disagree	1	3%
Disagree	11	28%
Disagree strongly	1	3%

Response	Do you agree with the proposal to cease collection of reference costs for community from 2020/21?	
	Number	%
Yes	27	69.2%
No	10	25.6%
Not answered	2	5.1%

3. Response to comments

Comment 1

You said

There are significant concerns regarding:

- The underlying availability, completeness, and accuracy of community activity data.
- Not all trusts have systems in place to collect activity data at a patient level.
- Not all data sets used by PLICS are mandated.

13. Issues with the underlying data was the main reason that mandation was delayed from 2020/21 to 2021/22. While NHS England and NHS Improvement understands that the accuracy of data is a significant issue, the voluntary submission of PLICS has already led to an improvement in the accuracy of data submitted to NHS Digital – improving from 42% in October 2019 to 62% in May 2020[2].

14. A number of other trusts specifically stated that mandating PLICS for community services, though difficult, will raise the profile of community at trusts and will enable more emphasis to be put on collecting and validating community data.

15. As with other sectors, where trusts have difficulties in collecting data at the required level, NHS England and NHS Improvement will work with them to support the development of the underlying national dataset requirements for electronic clinical data, improving future cost submissions and considering exclusion of costs where necessary. Such exclusions will be reviewed on an individual basis and trusts will be required to have an action plan in place to address this for future submissions.

[2] Review of NHS Digital data quality reports https://digital.nhs.uk/data-and-information/publications/statistical/community-services-statistics-for-children-young-people-and-adults

Comment 2

You said
The complexity and volume of the costing standards is a real issue, especially as trusts are at different stages of mandation depending on their main service. There have been a number of changes over the past few years and there are concerns that trusts will not be able to comply with all the required standards, especially given the impact of COVID-19.

16. As with other sectors, it is not expected that all trusts will be able to comply with standards for the first few years. There will be a transition pathway document[3] (over a three year period) which has been updated for the 2021 publication of the approved costing guidance, in advance of the start of the costed year (2021/22); this will form the mandatory collection in 2022. Therefore, trusts will be able to identify where they are not compliant with the standards and record this in their Integrated Costing Assurance Log (ICAL) and as part of their Board Assurance process.

17. Trusts will be expected to have a plan to address areas where they are non-compliant, and progress should be reviewed by the trust through their internal assurance arrangements. This will also be picked up through the Costing Assessment Tool (CAT) and the Costing Assurance Programme, with the findings used to identify what additional support can be provided.

18. However, the Costing team will continue to work with trusts to help them move towards full compliance with the standards, as has happened and continues to happen in other areas.

19. The volume of the documentation is also under review, and the team will continue to refine and reduce the size of the standards. As with other sectors, additional tools and guidance will be produced to help trusts implement and comply with the approved costing guidance, as well as reducing the burden on costing staff.

[3] This will be included in the Approved Costing Guidance

Comment 3

You said
Trusts are concerned about the impact of COVID-19 on the current cost collections, with staff being redeployed. Extending PLICS to community services, though a small area of spend for most trusts, significantly increases the burden on costing staff.

20. The Costing team have recently collected feedback on the impact of COVID-19 on the 2020/21 cost collection window, which will be published imminently. Guidance will also be published on how to cost the impact of COVID-19 and, as with the 2019/20 NCC, additional support will be available for trusts before and during the collection window.

21. As the mandation is for 2021/22, with the first collection in summer of 2022, it is expected that the impact of COVID-19 will have significantly reduced. Additionally, there will be another voluntary collection for 2020/21 in late 2021 or early 2022 with NHS Digital, which will allow more trusts to trial PLICS for community services, something which has been very beneficial in this and other sectors.

Comment 4

You said
The amount of spend on community services at most trusts and nationally is a small percentage of NHS spend. Trusts are concerned that any benefits of mandating PLICS for community services will be outweighed by the time and cost in implementing it, as well as taking more time away from validation of all costing data at a time when staff are being redeployed.

22. This is the last sector not costed or collected at a patient level. Having a single level of collection (with plans for a single collection for each trust) will mean trusts only need to have one costing system and will ensure consistency on how costs are apportioned across all services provided.

23. The collection of data at a patient level is a key part of the Long-Term Plan, including the move towards system-wide provision of services, allowing pathways to be planned and resourced across providers, so ensuring funding follows the patient. Patient-level data will allow better benchmarking of costs, both within organisations, but also across providers, to help identify efficiencies and new ways of working. As noted, we will continue to provide support for trusts in both 2020/21 and 2021/22 as the mandation comes into effect.

24. Where PLICS has been successfully implemented, making the validation of costing data (including costs, drivers of apportionments and activity data) part of the "business as usual" of trusts improves the accuracy of the data. Once established, the process can be automated, allowing the skill and knowledge of the costing practitioners to support service change in their organisation. This also allows the costing staff to focus on areas of concern or outliers from national or local benchmarking rather than on validating the underlying data.

Comment 5

You said
There are risks in ceasing the collection of aggregate data before PLICS is established for community services and the quality of data is sufficient for accurate costing.

25. Though this is a risk, other respondents have stated that this will allow them to focus on producing a single return, improve consistency of costing and put community services on a par with acute and mental health services, as well as increase the scrutiny and production of activity data. As noted, it will also mean trusts only need a single system, producing data at one level, except for the small number of services collected at an aggregate level.

Comment 6

You said
Given the impact of COVID-19 and recent mandation of PLICS for mental health services, could:

- the mandation be pushed back by a year, or
- a phased mandation be put in place

to allow trusts additional time to address the data quality issues and manage the impact of the pandemic on their staff?

26. As the first mandated collection will be in 2022, with another voluntary collection undertaken with NHS Digital support before that, NHS England and NHS Improvement believe that will allow ample time for trusts to prepare to submit patient-level data.

27. The process has already been delayed a year, and most of the respondents indicated that another delay will only undermine the Costing Transformation Programme and indicate that community services is not seen as important as other sectors. Also, community services are a fundamental part of providing "cradle to grave" services and will be the key to supporting system-wide costing and the proposed move to Integrated Care Systems.

28. The option of a phased implementation was also reviewed as part of the initial impact assessment. However, the complexity of this option meant it was rejected.

Comment 7

You said
The currencies collected and reported do not reflect much of the work of community services, with key concerns raised including:

- how to cost and treat “indirect patient contacts” such as safeguarding work
- the use of care contacts as the basis of costing, as these are not robust enough for accurate costing as they do not provide any information on the actual care provided.

29. NHS England and NHS Improvement’s Costing team will continue to work with trusts on ways to improve how costs are collected, including how to cost and record community activities appropriately and robustly. This will include those described as “indirect patient contacts”, where we have made significant changes for the 2021 publication of the approved costing guidance. The community early implementer group has contributed to many of these areas (and will continue to do so), using the data structures in the national dataset the Community Services Data Set (CSDS) wherever possible.

30. We recognise that there is more work to do, and part of this is working with NHS Digital to provide information on the future versions of the CSDS, so that the national data structures provide sufficient information for all purposes.

31. We are also working with the NHS England and NHS Improvement payment development team on the development of the community currencies, and these will be driven by the data in the CSDS. The proposed currencies have been clinically developed but will require costs at granular patient level to test the currencies, and to inform payment models of the future. We are aligning the costing activities to patient events that can be understood as part of these currencies.

32. The PLICS costed data, aggregated to their currencies, will also form part of the Model Community Health. We aspire to be part of the proposed outcome-based review of performance in the longer term. The components in the costing transformation programme structures will enable sufficient detail for review, until such time as currency issues are addressed.

Comment 8

You said
Costing is still seen as a financial process and there is often little or no senior or clinical engagement in costing.

33. The profile of costing has been raised through work by the Model System (Carter metrics) and the Get It Right First Time (GIFT) project, and it also forms part of the use of resources assessment. NHS England and NHS Improvement teams (including Model Health Systems and Pricing and Costing) will continue to work with providers to support the improvement in accuracy of the data being used for national assessment purposes.

34. We have seen in other sectors that because trusts are able to produce local PLICS on a more regular basis than the annual collection, this enables them to focus on their own priority areas. Providers can share patient pathway and cost data with staff outside of finance departments. This will not only improve the accuracy of the data but will also support the move to system-wide provision of services. The future ability to link cost data to patient outcomes will further support the benefits of this data in deciding how and where best to provide services.

35. The NHS England and NHS Improvement Costing team have met with many boards of directors and lead clinicians to discuss the benefits of PLICS and how it can be utilised. We are available to extend these meetings and offer supporting materials and case studies to community providers.

Comment 9

You said
The mandation does not cover non-NHS organisations, such as community interest or private companies, which means a significant amount of spend on community services will not be collected.

36. The Costing Transformation Programme has always aimed to collect PLICS data for all NHS services regardless of who provides them. The Costing team will continue to work with non-NHS providers to agree a methodology to collect costing data from them.

Comment 10

You said
The impact assessment talks about cost savings, but in reality, this could lead to additional activity for which there is no funding available and additional costs in respect of costing staff, IT staff and IT related costs. How will this be funded?

37. NHS England and NHS Improvement believes that introducing PLICS will help trusts identify the real cost of patient care and allow patient pathways to improve, which will allow better use of resources.

38. The cost data includes an estimate of additional time of both costing and associates staff, including IT, using data from the previous mandation of acute and mental health services. It also includes an estimate for new systems or system upgrades to implement PLICS for community services. It does not include the cost of any upgrades to information systems was not included as this will vary depending on each trust, the various systems it has in place and whether these can produce the required level of information.

4. Responses to future direction of travel questions[4]

Response	Do you agree patient-level costing returns should, in time, be submitted quarterly?	
	Number	**%**
Strongly support	1	2.6%
Support	10	26.3%
Neither oppose nor support	6	15.8%
Oppose	8	21.1%
Oppose strongly	13	34.2%

39. Benefits raised by the sector include:

- Quarterly reporting could help providers by smoothing out the resource effort needed so that it is across the year rather than the once a year approach.
- Makes data available in the actual reporting year which could be used to maybe correct actual events rather than just have a full year's data available that can only be used in an historical way – become business as usual.
- Would give organisations more up-to-date data with which to analyse their costs, and this would make Model Health System more useful as data would be available more frequently.

[4] These are additional questions, collected to help NHS England and NHS improvement understand whether a more frequent collection of community data would be beneficial. This does not form part of the formal consultation but is included here for information.

40. Concerns raised around more regular submission include:

- Ensuring the quality of the data collected and submitted, especially with reduction in time to take it to services and reviewing/correcting issues – more frequent collection would reduce time the small finance departments have to complete their costing work.
- Trusts would need to fully embed PLICS properly before any decision on more frequent collection is made – would this require another impact assessment?
- What would the data be used for and how would year-end adjustments be considered?
- There may be problems when trying to make local PLICS data fall into line

5. Trusts covered by the mandation[5]

Org Code	Organisation
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
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST
R1H	BARTS HEALTH NHS TRUST
RC1	BEDFORD HOSPITAL NHS 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

[5] Please let us know if there are any changes due to mergers or service transfers via costing@improvement.nhs.uk

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

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
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
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 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
RBQ	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST
REM	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
R1K	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST
RC9	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST
RPA	MEDWAY NHS FOUNDATION TRUST
RW4	MERSEY CARE NHS TRUST
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
RXF	MID YORKSHIRE HOSPITALS NHS 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
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
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
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
R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST
R1C	SOLENT NHS TRUST
RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST
RRE	SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST
R0B	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST
RAJ	MID AND SOUTH ESSEX 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 TEACHING HOSPITALS NHS TRUST
RWJ	STOCKPORT NHS FOUNDATION TRUST
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST
RDR	SUSSEX COMMUNITY NHS TRUST
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST
RBA	TAUNTON AND SOMERSET 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
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
RL4	THE ROYAL WOLVERHAMPTON 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 NHS FOUNDATION TRUST

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
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
RBK	WALSALL HEALTHCARE NHS TRUST
RWW	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST
RKL	WEST LONDON MENTAL HEALTH NHS TRUST
RGR	WEST SUFFOLK NHS FOUNDATION TRUST
RYR	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
RA3	WESTON AREA HEALTH NHS TRUST
RKE	WHITTINGTON HEALTH NHS TRUST
RY7	WIRRAL COMMUNITY NHS TRUST
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

RLQ	WYE VALLEY NHS TRUST
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST

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