



# **Patient Level Information & Costing Systems (PLICS) & Reference Costs Best Practice Guide**

April 2011

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<b>For Recipient's Use</b>	

# Patient Level Information & Costing Systems (PLICS) & Reference Costs Best Practice Guide

April 2011

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# Contents

<b>1. Purpose</b>	<b>4</b>
<b>2. Introduction &amp; Background</b>	<b>4</b>
<b>3. Use of Guide</b>	<b>6</b>
<b>4. PLICS &amp; Reference Costs</b>	<b>7</b>
<b>a. Key principles regarding PLICS and Reference Cost Compatibility</b>	<b>7</b>
<b>b. Adjustments to make for Reference Cost Submission</b>	<b>11</b>
<b>5. Document Development</b>	<b>17</b>

## 1. Purpose

- 1.1 The purpose of this document is to help support organisations using PLICS to produce Reference Costs, it does this by:
- identifying areas of costing and recording of information, which PLICS organisations need to be aware of when producing reference costs and
  - provides suggestions of best practice and workarounds used by NHS organisations to produce reference costs from PLICS data.
- 1.2 This guide was developed following consultation with the Healthcare Financial Management Association (HFMA) Costing Special Interest Group. Quotations within this guide predominantly come from members of this group.

## 2. Introduction & Background

- 2.1 During 2009 in partnership with the Audit Commission, the Department undertook the [Review of Reference Costs](#). Among the outcomes, the review highlighted issues for PLICS organisations when producing Reference Costs, specifically that there appeared to be difficulties in reconciling between the two sets of data. Within the resulting action plan, the Department of Health agreed to investigate this issue further stating the intention to:

“work with a number of implementers of patient-level information and costing systems (PLICS) to understand the interaction between reference costs and patient level cost data and, if appropriate, produce supplementary guidance to help PLICS sites in the production of reference costs.”

This guidance is the resultant output from this commitment.

- 2.2 The Department of Health has been encouraging organisations to implement PLICS for a number of years in order to improve the quality of cost data submitted to the Department. However, the prime reason for organisations to implement PLICS is to get a better understanding of their cost drivers. Good costing information is key to day to day management and is key to informing decisions making that improves the quality and cost effectiveness of services.
- 2.3 Improvements to the quality of Reference Cost data will ultimately feed through to improved tariff prices and as such, advances in costing via PLICS are encouraged.
- 2.4 Reference Costs are the mandated annual collection of costed activity data from all NHS provider organisations. The Department recognises that there are differences with the approach required to produce

reference costs to those used by organisations for local reporting using PLICS.

2.5 However, these differences do not mean that the production of reference costs is not possible for organisations who have implemented PLICS. Research and meetings in support of the development of this guide and other work has shown that, whilst producing reference costs requires adjustments to be made to PLICS data extracts, it remains a compatible process and can be done. The key messages for organisations using PLICS to produce Reference Costs is to:

- Understand the reference cost requirements
- Understand how their PLICS systems are set up and calculations are developed/processed
- Engage with software suppliers early
- Begin work on the production of Reference Costs early in the annual cycle.

2.6 The process has improved as organisations have developed their PLICS methodologies and as the use of and understanding of PLICS has improved. It is important that PLICS users have a detailed understanding of the reference cost requirements alongside the understanding of how their PLICS system has been set up.

2.7 Feedback from organisations using PLICS has supported the concept of producing reference costs when using a PLICS system, one NHS organisation using PLICS, defined the approach to producing reference costs from a PLICS data source as being:

*“very achievable but groundwork to understand how the PLICS system costs are built up is essential. As is, early in the reference cost cycle identifying where changes need to be made to the PLICS system to produce Reference Cost data. Engaging with your software suppliers to make adjustments within the PLICS system early in the process is key to avoid a raft of manual adjustments outside of your costing and information systems.”*

2.8 This guide seeks to identify areas for consideration and adjustments that may need to be made to produce reference cost submissions using PLICS data.

### **3. Use of Guide**

- 3.1 Due to the many different information and costing systems in use across the NHS it is not possible to offer a totally prescriptive methodology setting out how PLICS users should use their data to produce reference costs submissions. However, the purpose of this document is to identify key areas for consideration and highlight common adjustments which may need to be made to PLICS outputs in order to produce reference costs.
- 3.2 This guide will need to be used alongside the Reference Cost Collection Guidance and the NHS Costing Manual to produce reference costs for 2010-11. It is very important that the latest versions of the relevant guidance are used.
- 3.3 It is expected that organisations using PLICS will have been following the standards set out in the Clinical Costing Standards, first published by the Department in 2009 which provide guidance on using and establishing PLICS, describing best practice methodology's for PLICS users.
- 3.4 Going forward, organisations will be expected to use the Clinical Costing Standards 2011-12 published by the Health Finance Managers Association (HFMA) in April 2011. These standards update those previously published by the Department and can be found on the HFMA website via this link [PLICS Guidance](#). These revised Costing Standards have focused on clarifying the PLICS process and ensuring a more consistent approach across the service, reflecting changes within costing as a whole driven by national and international developments and best practice. Please note, organisations should use the 2011-12 standards for financial years 2011-12 and onwards only.

## **4. PLICS & Reference Costs**

### **Purpose & Use**

4.1 This section seeks to highlight the key areas where principles of Reference Costs and PLICS differ and identify specific areas of activity where treatment differs and detail examples.

### **Identification of differences relating to the production of Reference Cost data from PLICS data**

4.2 The key to producing reference cost data using PLICS data is to identify and document the:

- (i) different treatment of costs and activity. Organisations may chose to treat some costs and activity differently within their PLICS systems in order to meet internal reporting requirements / the needs of the organisation and
- (ii) adjustments required to income, expenditure and activity in order to bring reported costs and activity back into line with reference cost reporting requirements, particularly with any activity which has been bundled back in for PLICS reporting purposes, such as critical care activity & costs, but needs to be reported separately for reference costs.

4.3 The areas, which require attention, can be broadly grouped into two:

- (i) Key principles regarding PLICS and Reference Cost compatibility and
- (ii) Specific adjustments to make for reference costs.

#### **a. Key principles regarding PLICS and Reference Cost Compatibility**

4.4 Using a PLICS system will normally improve data quality and costing information within an organisation. Regular reporting internally on PLICS can highlight and resolve issues more quickly than a once a year exercise will allow. Therefore, using PLICS to support the Reference Cost submission will produce better quality data throughout the NHS.

4.5 The principle of Reference Costs involves establishing a control total from the general ledger and then making a series of cost and activity adjustments. These adjustments are fully explained within the reference cost guidance and can be found here:

<http://www.dh.gov.uk/en/Managingyourorganisation/NHScostingmanual/index.htm>



- 4.6 PLICS organisations need to ensure any adjustments are identified and applied within the correct cost pool groups to avoid skewing activity costs. Similar adjustments are necessary for Service Level Reporting (SLR), however this guidance does not cover SLR reporting requirements.
- 4.7 Organisations already successfully producing reference costs from their PLICS system report that using a simple checklist setting out all of these adjustments is extremely helpful and ensures a consistent approach year on year (see example template in annex 1). This can be drawn up well in advance of the production of reference costs and can be used in discussions with software suppliers and updated each year. The list will also enable costing professionals and auditors to understand the process and assumptions used in the current and previous years.

Adjustments that may be required in order to produce the reference cost submission include:

1. **Category C Income** – reference costs requires this income to be netted off whereas it will be included in most PLICS systems as gross income. As a result, this income needs to be identified and then credited within the PLICS system.

It is also important to ensure the credit is allocated to the appropriate places, for example, MADEL is credited against junior doctor's cost.

A judgement may also be needed in reconciling between the different treatments of PLICS and reference costs; for instance reference costs will require the netting down to be treated as producing neither a surplus or a loss, but PLICS and SLR may calculate whether an individual or service has benefitted financially from the Category C income. It is crucially important therefore that the varying approaches are checked and validated.

2. **Exclusions** – section 16 of the reference cost guidance contains details about all the excluded services, and parts of services excluded from reference costs. Organisations should ensure that the list is reviewed each year and highlight services to be excluded. PLICS users should track costs through the system to the correct area and/or set up within the PLICS model as separate products so costs as well as activity can be excluded.

Be aware that the exclusions for reference costs may be different to those used in the production of SLR reports.

As with the treatment of Category C income it is important to recognise the impact of the varying treatments and to check and validate the approaches. In particular, the reference cost treatment of Private Patients, which requires a working assumption of no surplus/loss may be

particularly challenging in a PLICS context, as it is likely that the calculated costs of a PLICS Private Patient will be below the figure charged.

- 3. Commissioned and sub-contracted services** – ensure that the PLICS system identifies the patients that are commissioned or sub-contracted and does not amalgamate them when producing the reference cost output. One organisation's approach is to:

*“identify patients within the PLICS system and send them to a separate product to allow recharge and identification for reference costs.”*

- 4. Separating out bed days and using trim points (for example Critical Care and Rehabilitation bed days)** - from inlier bed days. Using critical care as an example; this should be done automatically by the grouper. However, as critical care periods and rehabilitation episodes are included within PLICS costs and activity. Checks should be done against a sample of patients to ensure that the critical care and rehab activity has been removed from the episode before the excess bed day calculation. Trim points should be applied after all critical care and rehab adjustments have been made.

Some PLICS organisations may be able to show critical care either as part of the patient episode or separately for internal SLR, but the Reference Cost rules should be applied for the annual submission.

- 5. Adjustment to fixed internal corporate trading accounts**, (used for SLR reporting) – an organisation may use a 'contribution to overheads' approach to allocate costs to a specialty, as the direct and indirect costs are more controllable by the clinical service teams. This is appropriate for internal reporting, but all costs have to be absorbed into the relevant unit costs for the reference cost model. Care should be taken to make the correct approach for reference costs.
- 6. Adjustments to costing hierarchy** – hierarchy within an internal system may differ to the reference cost hierarchy (and output for the spreadsheets). For example, internal hierarchy may be Directorate/Division at the highest level, with drill down to Specialty, then Point of Delivery, then HRG and maybe beyond, whereas the reference cost workbooks forces the need to establish point of delivery between daycases, inpatients, regular day/night attenders and outpatients (as per the separate worksheets) and then to breakdown by treatment function code on the sheets themselves.

This may mean, for example, that in PLICS, when any costs are apportioned top down to a whole specialty, the methodology may need amendment when the specialty is already split for the relevant worksheets.

7. **Private Patients**, internal information using PLICS may wish to identify the profitability of private patients at a detailed level, to inform pricing and decision-making. For reference costs, the activity for private patients should be excluded, with the expenditure and income offset against the service area that provided the activity.
8. **Unbundled HRG Activity** – As a general area, the principle of unbundled activity necessitates adjustments to PLICS to produce reference costs. It is essential to consider the general guidance and adjustments needed, these include:
  - review each section considering the data available for each area
  - decide which data source contains the most accurate data quality
  - set up the calculation for Reference Costs (and PLICS if appropriate) to use that data
  - identify and apportion appropriate costs to it using appropriate weightings/information from the clinical team. It may be useful to retain the unbundled section in a service line (or sub-service line) of its own – or a cost pool, or cost pool group. (see Acute Costing Standards)
  - document the methodology & assumptions.

A solution to separately identify unbundled activity is to set up a service line or specialty within PLICS, which will aid the production of activity data such as critical care, chemotherapy, etc.

9. **Work in Progress (WIP)** – whilst identification and associated treatment of work in progress is not a PLICS only consideration, it is important that whilst using a PLICS approach that the correct treatment for reference cost regarding WIP is used. The main internal PLICS system will match activity to cost based on an episode end or even part completed episodes, following the accounting matching principle and will create a work in progress report. However, for reference costs an adjustment to reflect spells completed in year (bringing forward activity and costs for prior years) or incomplete spells being excluded from the current financial year for reference costs is required (details are included within the 2010-11 Reference Cost Guidance) and it is important that the associated costs are adjusted and PLICS systems are set up to do this.

## **b. Adjustments to make for Reference Cost Submission**

### **Purpose & Use**

- 4.9 This section is structured as per the reference cost submission worksheets for ease of use (the full worksheet list is included at annex 1).
- 4.10 Please note, the issues identified may not be applicable to all organisations. However, they are included as they may be relevant and require action. This list is not intended to be exhaustive, both additional issues and alternative workarounds may exist. The issues included here are identified as a result of feedback from PLICS practitioners. Some of the adjustments have been categorised as either cost or activity workarounds.
- 4.11 The key message for any manual activity and cost workarounds outside of the PLICS system is to ensure that:
- there is no double counting of activity and
  - that costs are correctly calculated using full absorption costing principles.

### **Inpatient & Day Cases**

*Issue* - Inpatients are costed at Spell level within some PLICS systems, whilst Reference Costs require an FCE approach.

*Possible Solution* - Inpatients can be costed at HRG level using the PLICS model. Systems can be set up to cost at FCE level, rather than at Spell level which would mean that the stay would not have to be disaggregated to FCE level for reference costs.

Similarly, Day Case activity can be costed at HRG level using a combination of the PLICS system and PAS systems. By setting systems up that can cost at FCE and Spell level, this facilitates various methods of reporting to be produced, when income is attached for both PLICS & SLR. By the nature of day case being single day, there is unlikely to be any spell adjustments, but unbundled areas may present a similar challenge.

### **Outpatient Attendances**

*Issue* – recording and allocating correct activity outside of the PLICS system.

*Possible Solution* - this is an area which may necessitate some manual adjustments, but the necessary action will be dependant upon information data flows. Below is an example of a costing workaround from an NHS provider:

*“Cancer Multi Disciplinary Team (CMDT), Allied Health Professional (AHP) and Obstetric ultrasound are not costed separately within the PLICS/SLR system. CMDTs are included within the job plans for the consultants. The total costs of each specialist MDT are then identified and repointed into the CMDT driver; they are then apportioned to speciality or HRG on a top down basis. AHP’s are subcontracted; the value of the contract is apportioned to the activity on a top down basis.”*

The corresponding activity workaround for the same organisation (below), highlights the range of information sources and thinking around data flows which needs to be co-ordinated:

*“CMDT, AHP and Obstetric ultrasounds require manual interventions to identify the activity for reference costs. CMDT data is obtained from the co-ordinator, which is held locally and in the correct currency. AHP activity is recorded locally as referrals, but is required as attendances and contacts in reference costs. An average multiplier is used to convert the referrals to contacts. All workarounds are manually imported to the system as service totals and are therefore not at patient level.”*

Please be aware that the recording of CMDT will not necessarily be recorded as an outpatient by the provider organisations as CMDTs do not have a patient attendance and as such are not by definition an ‘outpatient attendance’.

However, for reference costs, the classification of the activity is as an Outpatient, so adjustments to PLICS reporting outputs will need to be made. Issues regarding the treatment of activity within a PLICS system may relate to the appropriate use of TFCs, separating out and recording Multi professional attendances, and the inclusion of AHP/Technical services such as Physiotherapy, Orthoptists, Orthotics and so forth, and also Group sessions rather than individual contact, again for Therapists and Midwives. A weighting calculation can be used to split costs from either the number of professional or attender numbers.

## **A & E**

*Issue* - the main difficulty with A&E activity is reconciling which patients are admitted or not admitted, as the costs will vary between these two sets of patients and two different activity sets will need to be produced.

*Possible Solution* - An additional field/flag to show whether a patient was admitted or not could be added to the PLICS system to aid the collation of activity and costs for reference cost purposes.

Another adjustment required within A&E may be identifying dead on arrival patients and the associated costs. In most organisations, these patients are usually taken directly to the mortuary and recorded accordingly on the system.

However, the HRG for reference costs is reported on the A & E page, so costs and activity need to be extracted to report reference costs via A & E.

### **Specialist Services – Critical Care**

*Issue* - This guide has already discussed the need to extract bed days for critical care from the total inpatient spell. There may also be difficulty in extracting the activity data when using the grouped data.

*Possible Solution:*

*“Firstly users should ensure that the ITU/HDU episode is deducted from the overall length of stay and therefore adjust spell length of stay and ensure excess bed days are not erroneously produced”*

Organisations may have difficulty in collating the activity data due to the complexity of the HRG categories and data systems, therefore potential approaches used by providers may include costs not being weighted based on HRG.

A comment regarding difficulties with defining activity from an NHS provider is as follows:

*“The grouper only recognises one HRG per patient, the Grouper (PAS information) does not include all patient activity, and the grouper data is used as the basis of the calculation. The activity data from the ward is mapped to the grouped activity data. Additional patient lines are included where there are more than one HRG per patient. Where no HRG has been allocated to the patient, a HRG is mapped according to the average HRG from the ward/number of days. The amended patient level data is re-imported to the system.”*

The impact of contact with Outreach teams needs to be unbundled for PLICS, but not for the service cost in Reference Costs. A solution could be similar to that outlined for Specialist Palliative Care (below)

### **Community - Visits & Midwifery**

*Issue* – reconciling information flows to produce data

*Possible Solution* - not all PLICS organisations will have information flows linked to the PLICS system, or in some organisations, only part of the community data may be available in PLICS. If patient level data is not available, (whether in a PLICS or not), normal reference costs rules will apply. One organisation reported,

*“Costs from the community birthing centre are discrete and apportioned on a top down basis in lieu of PLICS information”.*

Identifying and linking activity data in this area may also require manual adjustments, in particular where activity is completed and compiled by other organisations. The same organisation reported that:

*“There was a need to split out the community element of the activity as the activity is provided by community sources regarding the number of community visits made from antenatal and postnatal visits. The activity is added to the system as a total for the service not at the patient level”.*

*“It may also be necessary to treat the Community Midwifery element in a similar fashion to AHPs in the example above, using an average multiplier for ante and post natal visits per birth in order to allocate costs. There may be an activity adjustment needed for ante natal visits for babies born at other units. It may be possible to use planned community clinic numbers as an indicator.”*

The longer-term objective should be to collect more community (and other) information at patient level, both for internal reporting, reference costs, and indeed to improve the quality of clinical information held.

## **Chemotherapy**

*Issue* – identifying activity and costs for chemotherapy.

*Possible solution* - several adjustments may need to take place to produce chemotherapy costs and activity. How easy this is will depend on whether chemotherapy is recorded within your PLICS system. The key element to chemotherapy is to understand how activity and costs across different departments are linked and what manual adjustments need to be made to produce costs for reference cost reporting.

For example, some organisations may record procurement HRGs information via the pharmacy system rather than by regimen, which means that no costs or patient activity levels are recorded at HRG level. The regimens followed could be identified by mapping the drugs used in chemotherapy to the regimen drugs.

For example, if the Pharmacy system records the issue of Carboplatin, Epirubicin and Vincristine, to the same patient on the same day, the regimen will be **CEV**, but if the drugs are Bleomycin, Cisplatin and Vincristine, the regimen will be **BOP**.

Organisations may need to make adjustments to ensure costs and activity is allocated to the correct service setting and patient, for example, ensuring that for chemotherapy delivery that ward costs are reported under the relevant reference cost workbook sheet. Dependant on the information systems and patient records, organisations might choose to use a manual check to trace activity to the patient; this could use minutes on the ward and number/type/time of pathology tests.

## High Cost Drugs

*Issue* - Extracting and reconciling the information from PLICS and pharmacy systems to produce reference cost data

*Possible Solution* – this is one area where manual adjustments may need to be made if the pharmacy and other systems are not linked in fully to the PLICS system. Flagging the drugs which are high cost within the system so automatically identified is one option, an activity work around undertaken by one Trust is as follows:

*“patient level information is available locally for non PbR drugs in the currency of patient months on treatment. Additional activity information is sought from pharmacy for the high cost drug s that are not PbR exclusions. The activity identified is manually input into the system via a dummy activity line at HRG/Point of Delivery level, not at a patient level.”*

Another organisation described their planned approach:

*“We should be able to map high cost drugs names to a HRG and remove the drug cost at the end of the costing process from everything except A & E. The issue is with the recording of activity as to whether we use coded information or the pharmacy system.”*

## Diagnostic Imaging

*Issue* – extracting required information to produce reference costs (this is not a PLICS only issue)

*Possible Solution* – this is one area where activity will need to be extracted from the PLICS system and different approaches may need to be used. Below are some examples which illustrate the different ways in which organisations resolve this issue:

*“Reference cost unbundles diagnostic imaging at a different currency (i.e. HRGS) to the internal PLICS bundled and matched diagnostic imaging (i.e. Modality/Examination Code/Korners) so cost weightings for both currencies were used but may not be comparable.”*

One organisation reported the following activity work-around,

*“ we had to exclude OP diagnostic imaging from the matching process, we still allocated radiology cost and activity to admitted patient care activity using patient number and dates to match, but OP unbundled radiology activity was worked up manually from the source data of the radiology system. This required interpretation of which scan codes fell into which HRGs, This left no connection between the original patient attendance and the diagnostic imaging”.*



## **Rehabilitation**

*Issue* – Extracting the rehabilitation days from within the inpatient spell

*Possible Solution* - Where the PLICS system is not yet established, in areas such as rehab, it may be necessary to use a top down cost apportionment. However, it is important to ensure that elements of overheads are built into this correctly. In addition, manual checks should be made to ensure data is not replicated on rehab attendances as WF prefixed HRGs.

Collecting the correct activity is important on areas produced outside of the PLICS system, for example:

*“As with ITU and HDU when calculating rehab as a bed day, it is important to ensure that rehab only starts from the date of transfer from acute care”*

## **Specialist Palliative Care (SPAL)**

*Issue* - Ensuring the correct costs and activity are extracted from the PLICS system correctly, potentially using manual approaches to activity.

*Possible Solution* – Palliative care costs should be identifiable from PLICS systems. However, activity information may have to be calculated. For example, activity may be provided by the SPAL team including number of minutes x weighting of time spent on bereavement, OP/OP, which would then allow accurate costing.

Often the key to collecting the correct activity is liaising with the palliative team or specialist nurse who will have the information and knowledge to identify activity correctly. There will also be a crossover with the recording of MDTs, as Palliative Care team members will be an integral part of the MDM

## **Direct Access – Pathology**

*Issue* – Extracting the split in activity as defined within reference costs

*Possible Solution* - Additional information may be needed to facilitate costing within the PLICS system in some organisations. Contact with the service may be needed to obtain activity information. Checks on the PLICS system as to whether the model splits out a proportion of costs for each pathology discipline based on the volume of work that is direct access compared to trust work is key to accurately costing the different activity.

## **5. Document Development**

- 5.1 As detailed above, this guide is not intended to be exhaustive and both issues and solutions have been obtained from a small number of organisations. PLICS practitioners should forward any additional issues and local solutions/work-arounds to [PLICS@dh.gsi.gov.uk](mailto:PLICS@dh.gsi.gov.uk) for inclusion in future versions of this document.

**Annex 1 Template for recording cost & activity adjustments to PLICS output to produce Reference Costs.**

<b>Workbook Sheet</b>	<b>Cost workarounds/approach</b>	<b>Activity workarounds/approach</b>
Daycase		
DCRA		
DCFRAD		
Inpatient		UZ episodes are allocated to an HRG based on either the diagnosis, the intervention, or the majority of the consultants practice. No UZ codes recorded in Ref Costs.
OP Attendances		
OP Procedures		
A&E		
SSS - Adult Critical Care		
SSS - Outreach Services		
SSS - Paed & Neo CC		
SSS - Coronary Care		
SSS - CC Transportation		
SSS - Cystic Fibrosis		
SSS - Cystic Fibrosis Band 5		
SSS – HAH		
Community & Outreach Nursing		
Community Nursing Services		
Community Therapy Services		
Community Rehab Teams		
Community - Vaccinations		
Community - Visits		
Community - Attendances		
Community - Midwifery		Assume a multiplier for visits in line with compliant NICE guidance. Minimum is 6 ante natal and 2 post natal visits per birth.
CHEMTHPY - Procurement		
CHEMTHPY - Delivery		
CHEMTHPY - Same Day Att		
HICOSTDRUGS - APC		
HICOSTDRUGS - OP & Other		
DIAGIM	We use the Radiology system as the basis for weighting cost. Each image has a "cost" on the Radiology system. This is used as the basis for recharging for all Imaging activity regardless of whether it is unbundled or not, and whether it is Direct Access or not. This ensures that the Ref Costs are produced on a consistent basis, but does mean that there is no internal benefit to our services of any Private Patient/GPDA making a surplus. I.e. Costs are set at a level base for all elements. If possible	

	assess whether the image types vary, and how this will affect episode/spell costs if applied more generically.	
RADTHPY - Inpatient		
RADTHPY - Planning		Utilise national benchmarks on planning courses per treatment as a comparator and adjust planning courses to exclude double counting.
RADTHPY - Treatment		
REHAB - per Attendance		
REHAB - per Bed Day		
SPAL - Inpatient & DC		
SPAL - OP & Other		
RENAL		
PTS		
HTCS		
Direct Access	The adjustment made in DIAGIM also applies to Pathology	Have to ensure that adjustments are made in the correct denomination.
Audiology - Hearing Aids		
Audiology - Fittings		
Audiology - Repairs		
Audiology - Screening		
MH - Occupied Bed Days		
MH - Patient Days		
MH - OP Attendances		
MH - Community		
MH - Specialist Teams		
Paramedic		