Left shift and neighbourhoods – implications and strategy for CHA members

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Edge Health for the CHA

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The Children's Hospital Alliance

The Children's Hospital Alliance is a trust-funded alliance of specialist children's hospitals, with 14 members across England and Northern Ireland. The network works together to improve the quality, access and experience of hospital care for children and families. The CHA and its member trusts seek to **learn**, **lead** and **advocate** for CYP.

The CHA network has been running for over a decade to support children's health leaders and practitioners in coming together to improve access, quality experience of children's hospital care.

A great strength of the CHA is our collective cohort of patients, often with rare diseases in small numbers that are difficult for one trust to tackle alone.

Across the CHA's English trusts, our members provide care to 3 million patients across our catchment areas, including:

- 4.53m contacts to children and young people every year
- 22.4% of children's hospital activity nationally
- 484,668 inpatient admissions – 61,792 of these are elective, and 192,364 are day case
- 3,379,098 outpatient attendances

With a total of 2,355 paediatric beds (286 of which are intensive care beds), our members hold 78% of the country's intensive care beds for paediatrics.

Why is data so important in paediatrics?

The availability of data and analytics within the paediatric world is so important. The tools that specialist children's hospitals have available to them has traditionally been limited, although tools like NHSE's SPaedIT dashboard has increased the visibility of data primarily within surgical specialties.

Historically, specialist children's hospitals have experienced:

- Poor data quality
- Difficulty accessing their own data within their larger trust infrastructure
- A lack of opportunities to see comparisons with their peers
- Paediatric data hidden amongst adult data
- Inappropriate or non-applicable paediatric metrics

The problems experienced above have meant that children and young people and their experiences may have been hidden within national policy and reporting mechanisms. The CHA seeks to amplify their voices driven by a rich pool of data.

Introduction to this piece of work

This piece of work aimed to inform CHA member Trusts (paediatric only) on the policy context and practical implications of realising the government's ambitions to shift activity to the community.

To provide a realistic picture, we worked to identify patients whose admission may be "divertible" to other services outside of the acute setting, and provided indications of costs, as a proxy for income.

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Data used in this analysis

The Children's Hospital Alliance has an agreement with NHS England's Getting It Right First Time (GIRFT) programme to access data for its 13 English Trusts. This means that this analysis could call upon a rich vein of data to support its conclusions.

The primary datasets used in this analysis were:

- **Inpatient Hospital Episode Statistics (HES)**
    - This dataset provides detailed patient-level information on diagnoses and treatments that take place in an inpatient setting (Elective and Non-Elective)
    - This was used for the bulk of the analysis, defining patient cohorts and assessing volumes of patients that may be affected by the left shift
- **Patient Level Information and Costing Systems (PLICS)**
    - This dataset shows records of precise activity and cost information for individual patient care
    - This was used to assess the potential fiscal impact of the left shift for specialist children's hospitals
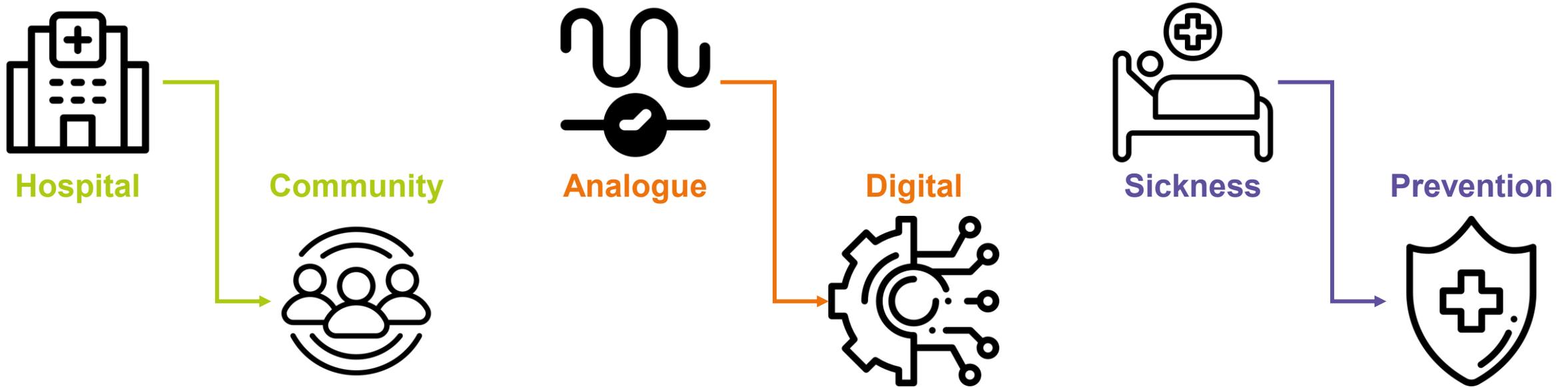
We also used publicly available data from the **General Practice Workforce Statistics** dataset to conduct correlations between primary and secondary care.

Context

Policy and Strategic Context: A New Vision

The NHS 10-year plan realigned the NHS strategic vision around 3 shifts:

Hospital → **Community**   **Analogue** → **Digital**   **Sickness** → **Prevention**

As part of this strategic realignment, the left shift seeks to move care away from acute hospitals and into integrated, community-based Neighbourhood services. The idea behind the left shift states care should be delivered at the most local and least intensive level that is clinically appropriate.

Care should happen "digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, and in a hospital where necessary".

Policy and Strategic Context: The Neighbourhood

The neighbourhood model for CYP is designed to integrate with the wider support system, including Family Hubs, schools, and nurseries.

Young Future Hubs

Mental Health Support Teams

Neighbourhood MDTs

"My Child" Digital Record

Specific initiatives include expanding Mental Health Support Teams in schools, developing Young Futures Hubs for easier access to mental health support, and introducing a "My Child" digital record on the NHS app as a modern alternative to the paper-based "red book".

The service will be delivered by a **Neighbourhood Multidisciplinary Team (MDT) -** made up of at least a GP, community paediatrician and mental health practitioner.

Policy and Strategic Context: Funding and Structure

A central commitment of the 10-year plan is that **"funding will follow"** the patient out of the hospital and into the community. This means a significant portion of NHS investment may be redirected from acute hospitals towards primary and community care over the coming years.

The plan also proposes that the best-performing NHS trusts can become 'Integrated Health Organisations' (IHOs), a single organisation that would be responsible for managing and delivering the **full range of health services** for a defined population. IHOs could lead to more seamless and coordinated patient care, reducing duplication and a greater focus on public health and prevention.

IHO

| Acute Hospitals | Community providers | Primary Care | Mental Health providers | Local non-health services |
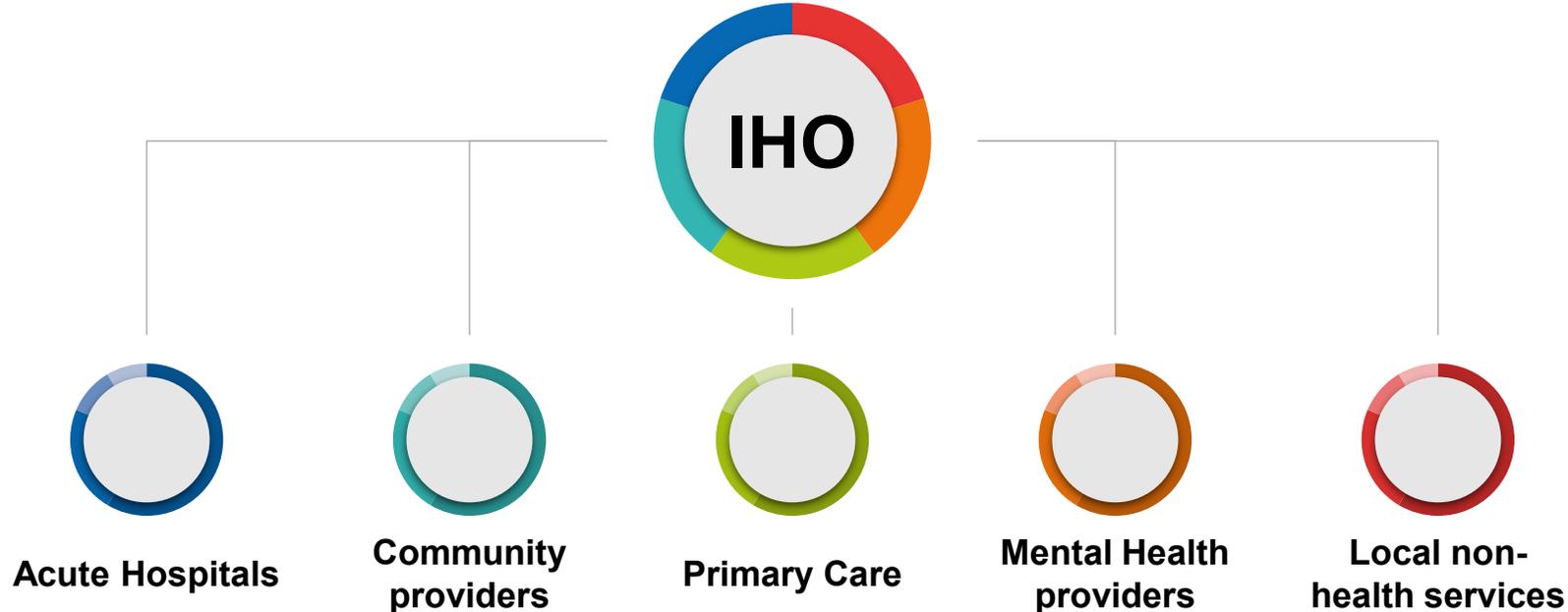
By creating a single entity responsible for the whole pathway of care, the IHO is directly incentivised to invest in preventative and community-based services to keep its population healthy, thereby reducing demand on its own high-cost acute services.

Left-shift impact analysis

Understanding the Impact

With the NHS's focus pivoting to the **community**, **prevention** and **digital**, we considered the potential impacts on CHA Trusts, and opportunities to actively support changes.

To answer this, we have attempted to capture "divertible" admissions: those with a higher likelihood of being preventable, or at least manageable outside the acute setting. We have identified the following within **non-elective admissions**:

| Ambulatory-Care Sensitive Conditions | Very short stays | Low clinical intensity (not meeting PAEP criteria) |

Using academic definitions, we identified admissions considered "ambulatory-care sensitive" (**ACSC**).

These typically include:
i. Acute conditions like ENT infections, gastroenteritis and pneumonia;
ii. Chronic conditions like asthma and epilepsy;
iii. Vaccine-preventable conditions like measles.

We considered NEL/EM admissions lasting up to 24 hours (**0-1 days**), as a potential marker for care that could have taken place outside of hospital.

This is based on the concept of the Paediatric Appropriateness Evaluation Protocol (**PAEP**) to identify admissions that may be less appropriate for an acute inpatient setting.

For this, we have attempted to translate the PAEP methodology using ICD-10 and OPCS codes in HES to identify clinical acuity and treatment intensiveness.

Paediatric Appropriateness Evaluation Protocol

The Paediatric Appropriateness Evaluation Protocol (PAEP)[1, 2] is a tool designed to assess the appropriateness of paediatric hospital admissions and bed days. It provides a set of objective guidelines for clinicians to evaluate the medical necessity of a child's hospitalisation. If **one or more items** are present, the admission or day is labelled *appropriate*. If **none** are present, it is flagged as *potentially inappropriate*.

For the purpose of our analysis, we have tried to match PAEP criteria to admissions using ICD-10 and OPCS codes. For example:

- Any diagnosis code that is considered 'high-risk', for example:
  - **D570- Sickle-cell crisis**, requires urgent specialist care
  - **R0420- Unspecified Coma**, airway and brain protection is critical
  - **G41- Status epilepticus**, can permanently injure the brain
- Any procedure code that is considered 'high acuity', for example:
  - **A55- Lumbar puncture/spinal tab**, usually only ordered for suspected meningitis or sub-arachnoid bleed
  - **E85.x- Ventilation support**, for patients who cannot maintain their own airway or blood glass levels
  - **X40- Dialysis** (non-elective), only ever started when kidneys fail

[1] Esmail A. Development of the Paediatric Appropriateness Evaluation Protocol for use in the United Kingdom. J Public Health Med. 2000 Jun;22(2):224-30. doi: 10.1093/pubmed/22.2.224. PMID: 10912564.
[2] Werneke U, Smith H, Smith IJ, Taylor J, MacFaul R. Validation of the paediatric appropriateness evaluation protocol in British practice. Arch Dis Child. 1997 Oct;77(4):294-8. doi: 10.1136/adc.77.4.294. PMID: 9389230

Cohorting Methodology

The combination of the three factors can provide a proxy for how likely an admission is to be divertible and therefore be appropriate for community care.

By overlapping the three, we have identified three cohorts:

1. **Low Confidence Cohort:** Admissions flagged by only one factor (e.g., only ACSC and not short-stay and non-PAEP).

2. **Moderate Confidence Cohort:** Admissions flagged by any two of the three factor (e.g., ACSC and short-stay).

3. **High Confidence Cohort:** Admissions flagged as ACSC *that were also* short-stay *and* did not feature any "PAEP" criteria.

The highest confidence group is likely to be the best fit to identify admissions that are most likely to be appropriate for out-of-hospital management.

The cohorts selected here are to cover potentially "universally divertible" admissions. This represents a starting point for activity that could take place outside of hospital.

However, we are aware that individual Trusts have expanding out-of-hospital care for traditionally hospital-based cohorts, such as virtual wards or long-term ventilation.

We encourage shared-learning and discussions of initiatives to promote innovative ways to provide care outside of hospital.
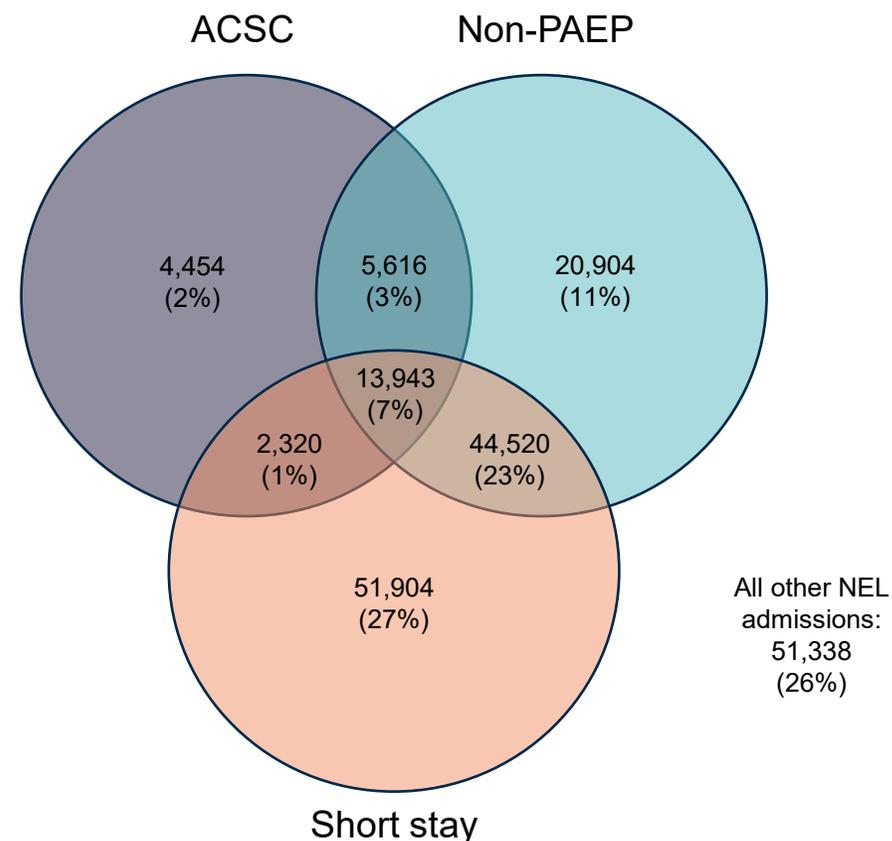
Volumes of divertible admissions (2024-25)

As expected, applying increasingly stringent criteria results in smaller cohorts of potentially divertible admissions:

- **Moderate Confidence Cohort (two or more criteria met):** When admissions meet two (or more) out of three criteria, **34%** are identified as potentially divertible.

- **High Confidence Cohort (all three criteria met):** Using the most conservative definition, **7%** of admissions may be seen as potentially divertible.

The analysis that follows focuses on the **high confidence cohort**, as this most accurately reflects safe and practical opportunities, capturing only those admissions more likely to be managed adequately in the community.

ACSC

Non-PAEP

4,454 (2%)

5,616 (3%)

20,904 (11%)

13,943 (7%)

2,320 (1%)

44,520 (23%)

51,904 (27%)

All other NEL admissions: 51,338 (26%)

Short stay

Volumes of divertible admissions (2024-2025)

| Trust	Moderate confidence volumes (two or more criteria met)	High confidence volumes (all three criteria met)
Anonymised	55%	13%
	44%	11%
	40%	10%
	45%	9%
	35%	8%
	45%	8%
	37%	8%
	29%	5%
	22%	4%
	20%	3%
	23%	3%
	8%	1%
	7%	0%
Total	**34%**	**7%**

Potentially divertible admissions make up **~7% of all CHA non-elective admissions**.
But there is considerable variation between providers.

Volumes of divertible admissions (2024-2025)

**Proportion of admissions that are divertible by Trust - High Confidence**
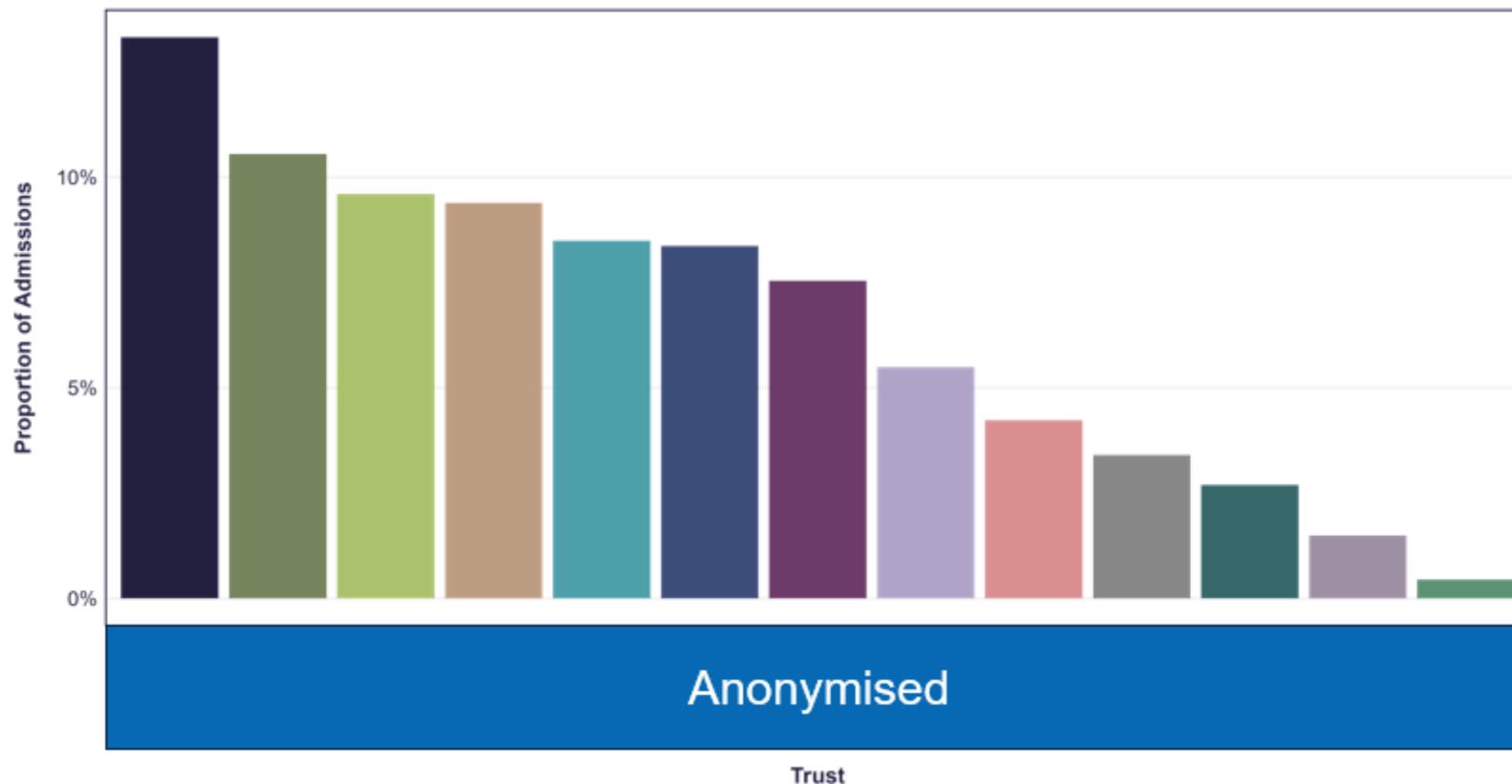
The Trusts vary in the proportion of admissions that could be divertible within the high confidence cohort.

The reasons behind this are harder to pinpoint, and range from context (deprivation, availability of alternative care, health behaviours) to strategic positioning of Trusts as a hub for the community to turn to.

Age- Volumes of divertible admissions (2024-2025)

Proportion of divertible admissions within each age group - High Confidence
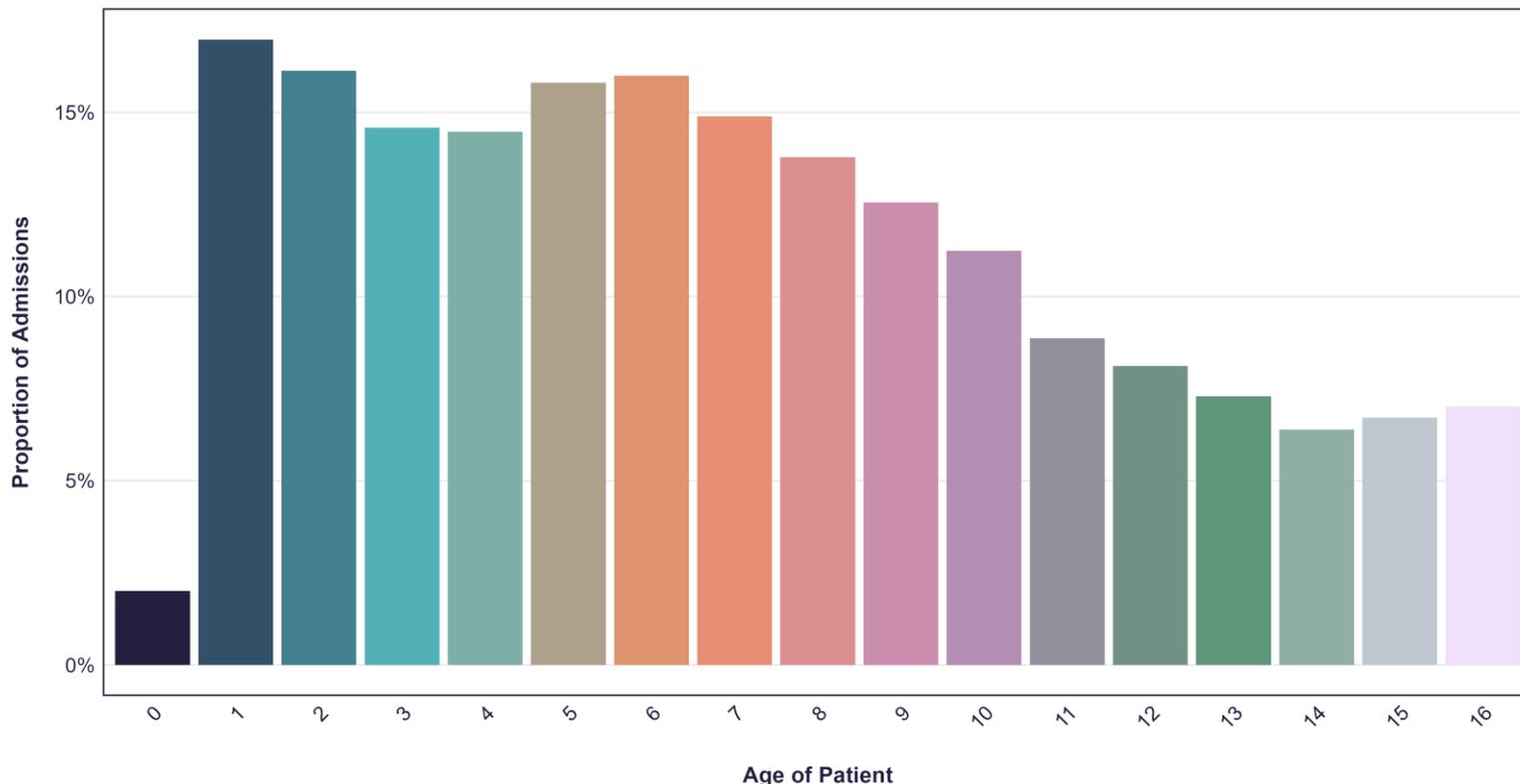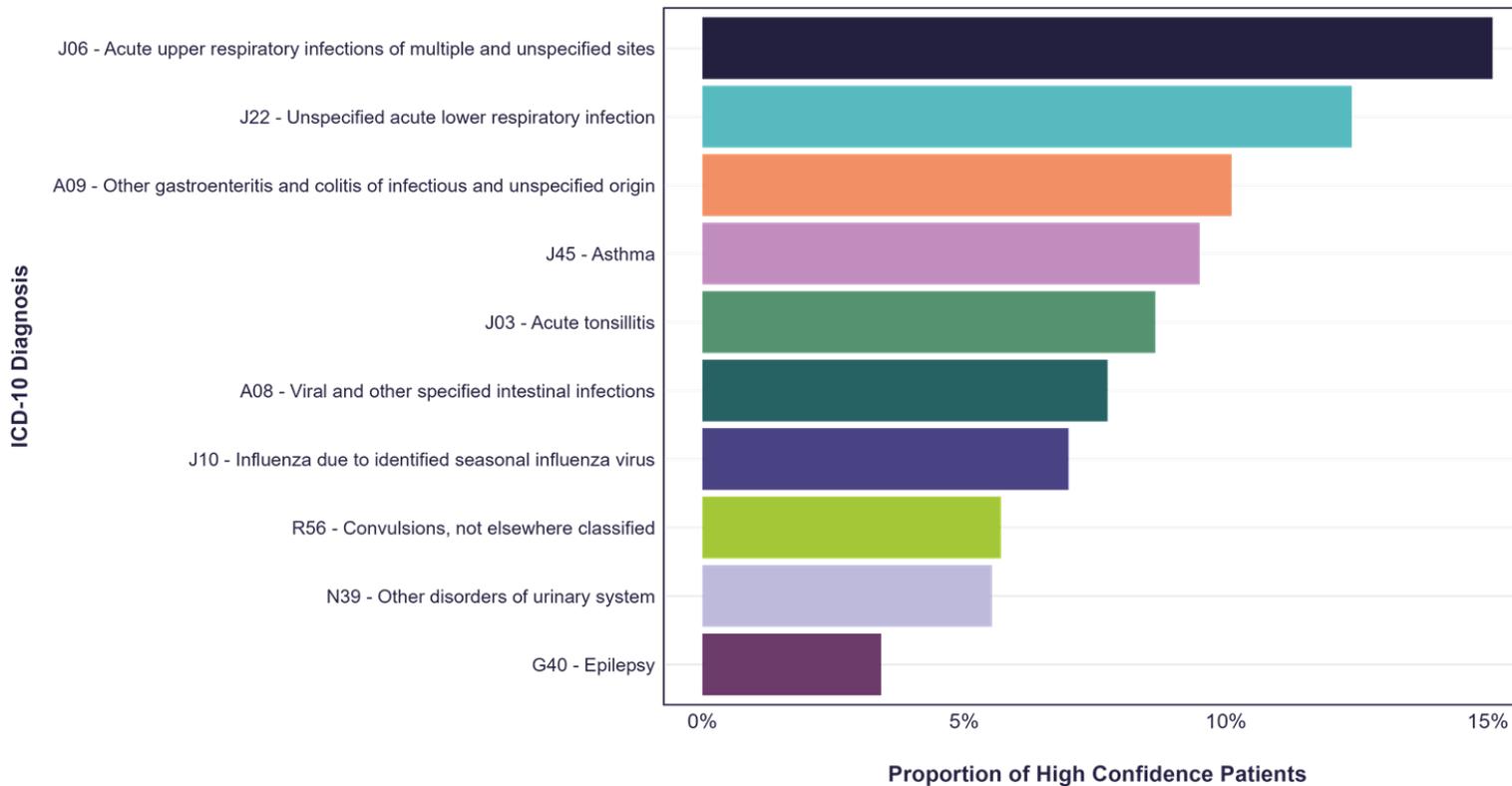

Divertible admissions are more common amongst children between 1 and 10 years old, compared to the very young and older children.

This suggest potentially relevant opportunities to provide support through family hubs and/or primary schools.

Diagnosis- Volumes of divertible admissions (2024-2025)

Top 10 Diagnoses - High Confidence

Chart: Proportion of High Confidence Patients (x-axis) vs ICD-10 Diagnosis (y-axis)

- J06 - Acute upper respiratory infections of multiple and unspecified sites
- J22 - Unspecified acute lower respiratory infection
- A09 - Other gastroenteritis and colitis of infectious and unspecified origin
- J45 - Asthma
- J03 - Acute tonsillitis
- A08 - Viral and other specified intestinal infections
- J10 - Influenza due to identified seasonal influenza virus
- R56 - Convulsions, not elsewhere classified
- N39 - Other disorders of urinary system
- G40 - Epilepsy

Respiratory conditions are the most common amongst divertible admissions.

This suggests that a focus on respiratory conditions in the community could be beneficial; for example, paediatric respiratory virtual wards, primary care education or school support.

Note that R56 and G40 are both seizure related. Ensuring appropriate epilepsy management in the community could be beneficial.
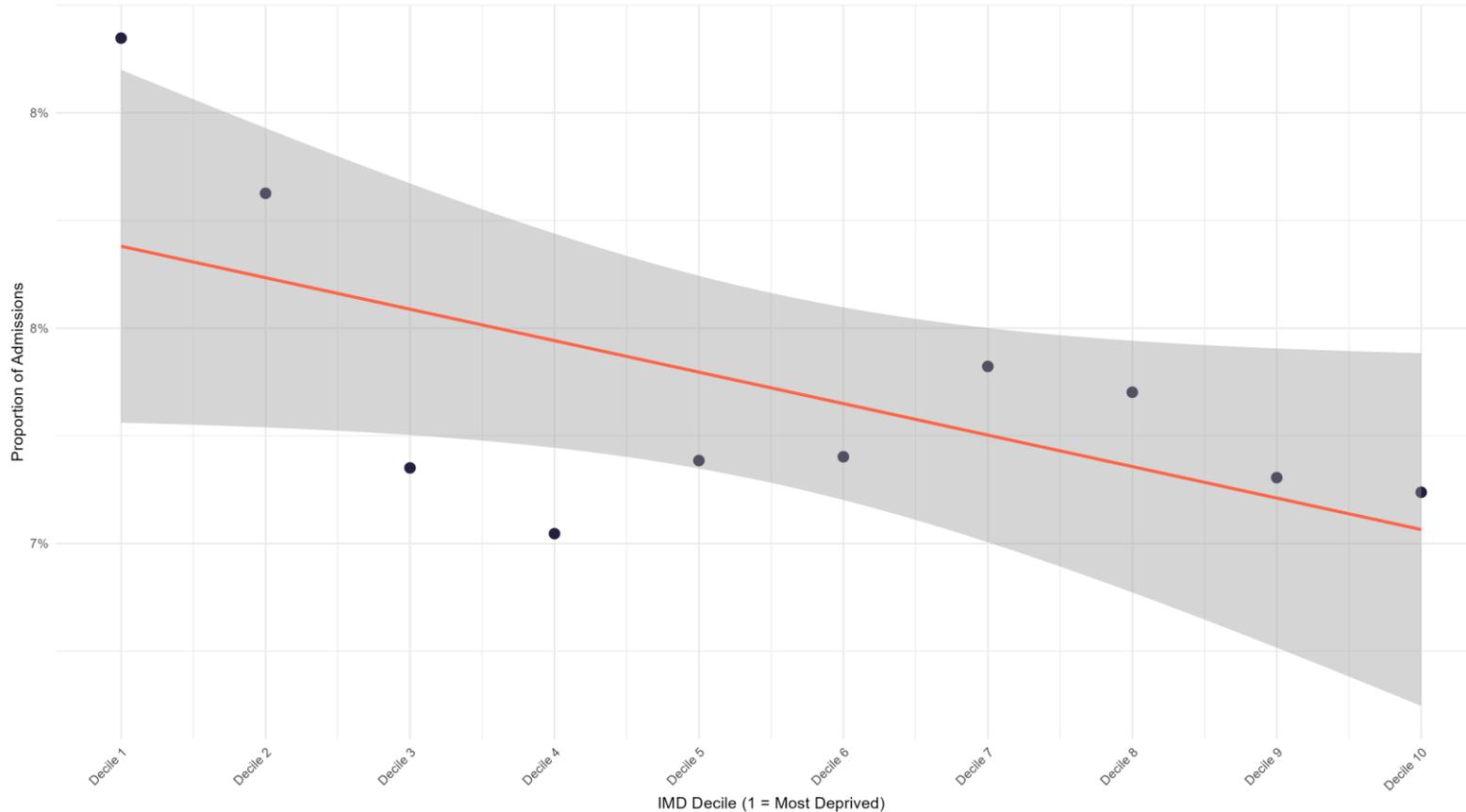
1-8-year-olds

The most common diagnoses are **upper and lower respiratory infections (unspecified)**.

9-16-year-olds

Asthma is the primary diagnosis for nearly 20% of high-confidence divertible patients.

Demographic factors – deprivation

Correlation between Divertible Admissions and IMD Decile (High Confidence)
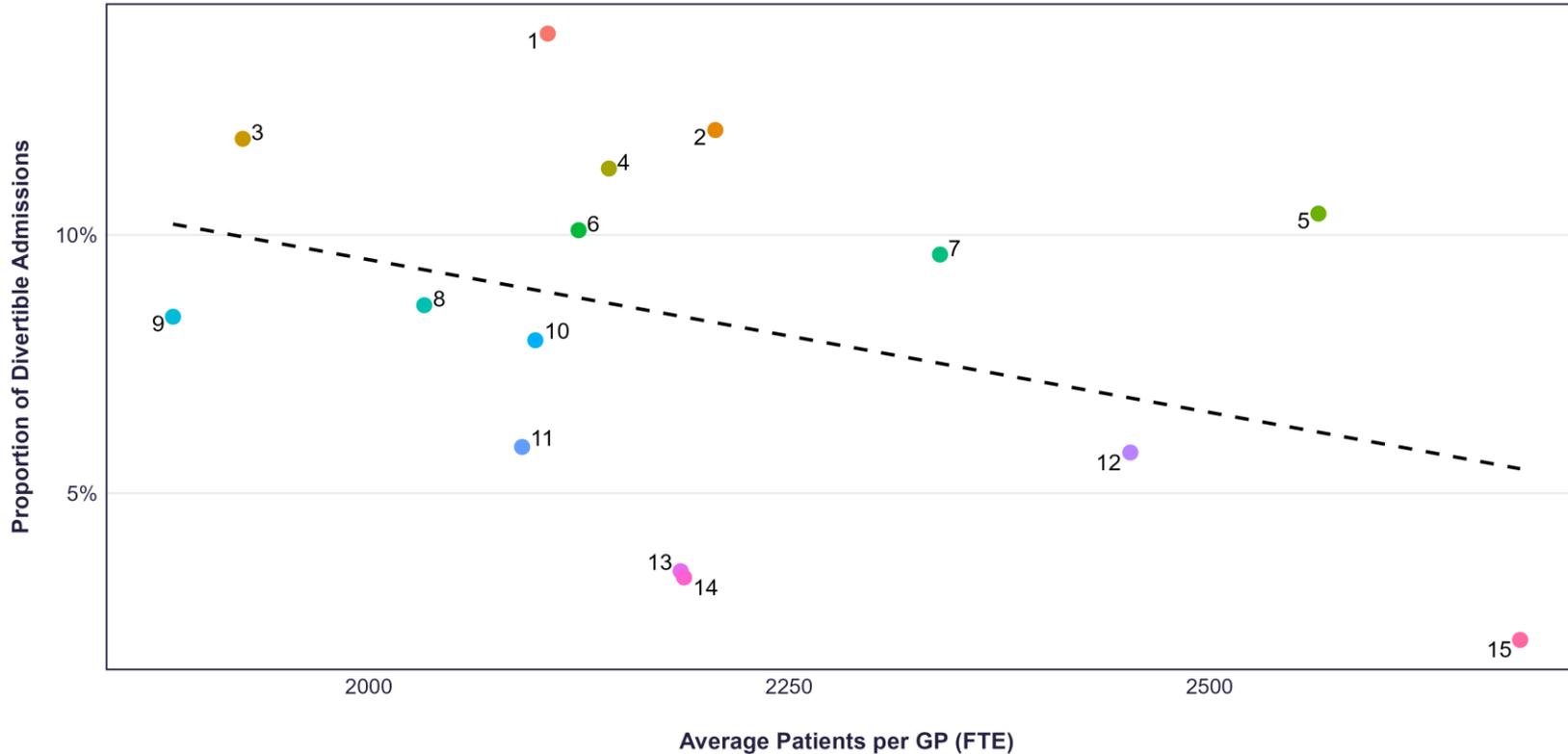
A weak but significant negative correlation was found between IMD and high confidence divertible admissions (r = -0.01, $p < 0.001$). This suggests that patients coming from a more deprived area are slightly more likely to have admissions identified as potentially divertible.

Further analysis revealed that the relationship between IMD and divertible patients was largely driven by two Trusts. At Trust A, a weak but significant negative correlation was found (r = -0.05, $p < 0.001$), with a similar relationship observed at Trust B (r = -0.06, $p < 0.001$). This suggests that, at these Trusts, divertible admissions are more likely to come from more deprived areas. When excluding these two Trusts, the negative correlation is no longer observed.

Primary care capacity

Patients per GP by Proportion of Divertible Admissions

ICBs with >100 divertible admissions

Number in figure	ICB*	Divertible admissions	Proportion of admissions divertible
1		1,841	14%
2		1,788	12%
3		311	11%
4		108	11%
5	Anonymised	1,709	10%
6		1,609	10%
7		1,595	10%
8		190	9%
9		1,385	8%
10		885	8%
11		278	6%
12		137	6%
13		772	3%
14		511	3%
15		111	2%

A weak negative correlation was found between the number of divertible patients and the number of patients seen by a GP in the same region, which was not significant (r = -0.37, p = 0.17). This suggests that an increased number of patients seen by GP does not necessarily correspond to a lower proportion of divertible admissions.
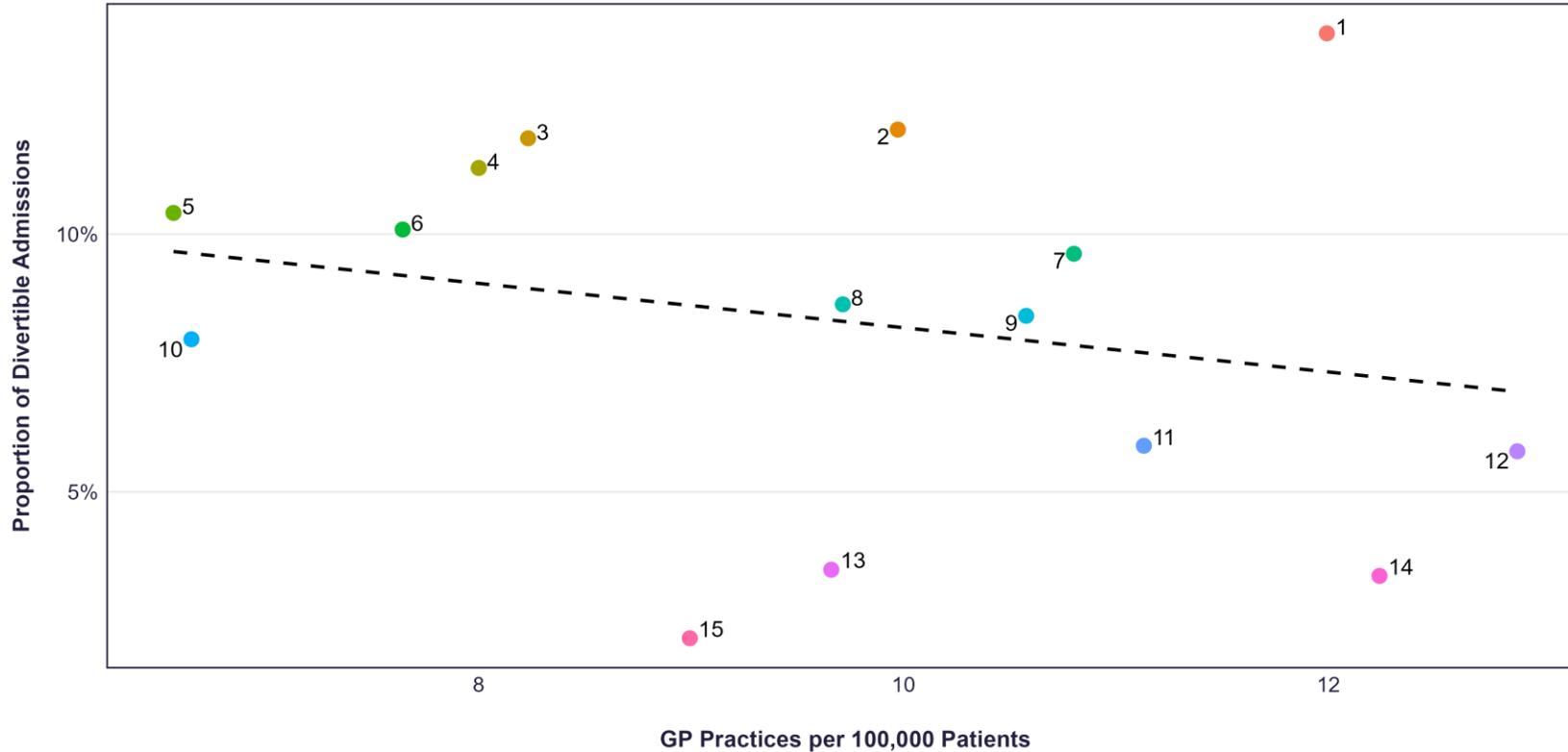
*Only ICBs with more than 100 divertible cases are shown, as volumes are very low for other ICBs.

Primary care capacity

GP Practices per 100,000 Patients by Proportion of Divertible Admissions

ICBs with >100 divertible admissions

Despite a weak trend of regions with more practices having less divertible admissions, a significant correlation was not found (r = -0.24, p = 0.31). This suggests that an increased number of GP practices does not necessarily correspond to a lower proportion of divertible admissions.

*Only ICBs with more than 100 divertible cases are shown, as volumes are very low for other ICBs.

Number in figure	ICB*	Divertible admissions	Proportion of admissions divertible
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Potential drivers

We considered several potential factors that may contribute to higher volumes of divertible admissions:

Demographic factors (age, gender, ethnicity)

While there is variation amongst age groups, as discussed, we **did not find any significant differences** in divertible admissions based on gender or ethnicity.

Deprivation

There was a **weak but significant correlation** between higher deprivation and divertible admissions when considering CHA-wide data.

However, this was much stronger for **Trust A and Trust B**, and it may relate to the Trusts' wider context.

Tackling deprivation may result in more significant benefits on divertible admissions at these two trusts.

Access to Primary Care

Across all CHA Trusts**, no significant correlation** were found between GPs per registered population and the proportion of divertible admissions.

Wider Context

There is likely to be a wide range of other factors that would require more consideration, such as:
- The **type of services** offered by a Trust to the community
- The availability of **alternative hospitals** or acute services
- Coverage of services like **health visiting, social care**
- Availability of **in-school** support
- Other factors influencing local **health behaviours**

The cost of divertible admissions

We used costs and activity data from 2023/24* to assess the financial impact for CHA Trusts.
Here we focused on **variable costs** (e.g. bloods, drugs and imaging).

£4.6 million	**2.2%**	**£341**
spent on 13,500 divertible admissions	of total CHA expenditure on NEL admission	spent on average per divertible admission

- 4 CHA Trusts spent **over half a million each** in 2023/24 on admissions that may have been divertible.
- The most spent across the CHA as a percentage of non-elective admissions spending was 5%.

These costs represent an **opportunity** as well as an **operational challenge** – costs may be a proxy for income, so Trusts looking to support moving this activity out into the community should plan how income changes may affect them.

* Note: no PLICS data available for 2024/25, but 2023/24 volumes were highly comparable with 2024/25. Divertible admissions with PLICS data in 2023/24 made up 10% of CHA NEL admissions.

Conclusions

This presentation has covered the left shift from acute to the community, defined which patient groups are primed for being care for in non-acute settings and assessed the magnitude of these groups. We highlighted opportunities for CHA Trusts to support the left-shift and build relationships to be part of future decision-making.

In conclusion, this presentation has highlighted that:

- **13,943 non-elective admissions** across the CHA per year could be diverted away from acute settings and effectively managed within the community. This accounts for **7%** of the CHA's overall non-elective admissions.

- These divertible admissions are commonly **respiratory conditions** such as asthma and acute tonsilitis, whilst **seizure related conditions** also feature prominently.

- **£4.5 million** spent across the CHA on variable costs for 'divertible' admissions, at a cost of nearly **£350** per patient.

- Strategies for managing some of these divertible conditions in the community: empowering patients through **education and technology**, provide **joint care and train staff** in the community, set-up **virtual wards**.

- Each CHA Trust should seek to **build relationships** within all-age providers, Provider Collaboratives, and within primary and community settings to ensure that they can **provide expert input** in the set-up of community services, as well as **have a say on funding/commissioning decisions** in a world where funds may flow from IHOs.

Appendix

Ambulatory Care Sensitive Conditions (ACSCs)

ACSCs are conditions for which hospitalisation is considered potentially avoidable with timely and effective care in a community or primary care setting.

Several piece of literature have identified ACSCs relevant to CYP[1, 2, 3, 4]. These can largely be divided into three groups:

1. **Acute conditions:** For many common, self-limiting acute illnesses, community-based management is the recommended and most effective approach.

2. **Chronic conditions:** Proactive and well-organised community care can prevent acute exacerbations that frequently lead to emergency hospital admissions.

3. **Vaccine-preventable conditions:** The UK's routine childhood immunisation schedule provides early protection against a range of infections that were historically major causes of hospitalisation

[1] Purdy, S., Griffin, T., Salisbury, C., & Sharp, D. (2009). Ambulatory care sensitive conditions: terminology and disease coding need to be more specific to aid policy makers and clinicians. *Public health*, *123*(2), 169–173.
[2] Cecil, E., Bottle, A., Ma, R. et al. Impact of preventive primary care on children's unplanned hospital admissions: a population-based birth cohort study of UK children 2000–2013. BMC Med 16, 151 (2018).
[3] ACS Listing (ICD-9-CM Groupings): Institute of Medicine, "Access to Health Care in America", Michael Millman, Ph.D, Editore, National Academy Press, Washington, D.C., 1993.
[4] ACS Listing and (ICD-10-CM Groupings): John Billings, Professor, Director, Health Policy and Management Program. Robert F. Wagner School of Public Service, New York University.

Paediatric Appropriateness Evaluation Protocol

Category	Criterion
Severity of Illness	A. Sudden onset of unconsciousness (coma or unresponsiveness) or disorientation.
	B. Acute or progressive sensory, motor, circulatory or respiratory embarrassment sufficient to incapacitate the patient (e.g., inability to move, feed, breathe).
	C. Acute loss of sight or hearing.
	D. Acute loss of ability to move a major body part.
	E. Persistent fever (≥37.8°C orally or ≥38.3°C rectally) for more than 48 hours where a diagnosis has not been established.
	F. Active bleeding which could lead to circulatory embarrassment if haemostasis is not secured.
	G. Wound dehiscence or evisceration.
	H. Severe electrolyte/acid–base abnormality (e.g., Na ≤123 or ≥156 mmol/l; K ≤2.5 or ≥5.6 mmol/l).
Intensity of Service	1. Surgical or procedural intervention under general anaesthesia requiring post-operative monitoring.
	2. Administration of intravenous medication and/or fluid.
	3. Close monitoring (at least every 2 hours) of vital signs, neurological status or fluid balance which cannot be provided in an alternative setting.
	4. Use of supplemental oxygen which cannot be provided in an alternative setting.
	5. Any treatment or procedure requiring equipment that cannot be provided in an alternative setting.
	6. Need for investigation of child abuse where there is no alternative safe environment for the child.
	7. Need for investigation of a medical condition where there is no alternative setting for the investigation to be carried out.

This table shows the list of PAEP criteria. These criteria have been matched to diagnosis (ICD-10) and procedure (OPCS) codes to identify PAEP and non-PAEP admissions.

PAEP: ICD-10 Translation

Category	ICD-10 Code
Haematological / Acute Crisis	D57.0 – Sickle-cell anaemia with crisis
	D62 – Acute posthaemorrhagic anaemia
	D68.3 – Haemorrhagic disorder due to circulating anticoagulants
	D69.9 – Haemorrhagic condition, unspecified
Neurological	G41 – Status epilepticus
	G81 – Hemiplegia
	G82 – Paraplegia and tetraplegia
	G83 – Other paralytic syndromes
Respiratory	J96 – Respiratory failure
	J80 – Acute respiratory distress syndrome
	J86.9 – Pyothorax without fistula
Perinatal / Neonatal	P22 – Respiratory distress of newborn
	P29 – Cardiovascular disorders originating in the perinatal period
Shock / Sepsis / Systemic Instability	R57 – Shock, not elsewhere classified
	R65 – Systemic inflammatory response syndrome
Consciousness / Acute Collapse	R40.2 – Coma, unspecified
	R40.4 – Transient alteration of awareness
Metabolic / Electrolyte	E87 – Other disorders of fluid, electrolyte and acid-base balance
Haemorrhage	R58 – Haemorrhage, not elsewhere classified
Sensory Loss	H54 – Blindness and low vision
	H90 – Conductive and sensorineural hearing loss
Injury / Trauma	S02.10 – Fracture of base of skull
	T74 – Maltreatment syndromes
	T81.3 – Disruption of operation wound
	X59 – Exposure to unspecified factor
Other	R23.0 – Cyanosis
	Z51.3 – Blood transfusion

Admissions were flagged as clinically appropriate for inpatient care (i.e., PAEP) if any of these ICD-10 codes were recorded.

PAEP: OPCS Translation

Category	OPCS Code
General anaesthesia / operative intervention	A55 – E85 – E87 – E89 – E25 – E24 – E48 – E49 – E50 – E51 – E35
IV therapy proxy (venous access / infusion-related procedures)	X40 – X50 – X51 – X52 – X56
Oxygen therapy / respiratory support	X58
Complex diagnostic evaluation (imaging / invasive diagnostics)	X32 – X33 – X34
Transplant / major aftercare	Z94
External Cause / Complex Injury Markers	Y* – W36 – W90 – T12 – T41 – S55 – S57 – H* – L91 – L99 – U05 – U07 – U211 – U212 – U213 – U214 – U215

Admissions were flagged as clinically appropriate for inpatient care (i.e., PAEP) if any of these OPCS codes were recorded.

Short stay unplanned admissions

We considered short-stay admissions as a further category to stratify admissions, building on published evidence[1,2] suggesting that short-stay admissions may be a marker of care that could be safely provided in the community. A rise in short stay admissions (< 2 days) was correlated with reduction in primary care support, higher rates of deprivation, parents' confidence in the support they could receive outside of hospital.

Here we defined short-stay admissions as lasting for **< 2 days**, following the definition used elsewhere in literature.

We recognise that some short-stay admissions may be entirely clinically appropriate. Therefore, this indicator should not be used in isolation when considering divertible admissions. Nonetheless, if a child or young person is hospitalised for less than 24 hours, it raises the question of whether the care that they received could only be provided in an acute hospital setting or whether it could have been effectively managed in a community setting.

[1] S Saxena, A Bottle, R Gilbert, M Sharland. (2009). Increasing short-stay unplanned hospital admissions among children in England; Time Trends Analysis' 97–'06
[2] King, E., Dick, S., Hoddinott, P., Malcolm, C., France, E., Kyle, R. G., Aucott, L., Wilson, P., & Turner, S. (2023). Regional variations in short stay urgent paediatric hospital admissions: a sequential mixed-methods approach exploring differences through data linkage and qualitative interviews. BMJ open, 13(9), e072734. https://doi.org/10.1136/bmjopen-2023-072734

Volumes of divertible admissions, 1–8-year-olds (2024-2025)


Top 10 Diagnoses - High Confidence (Ages 1–8)
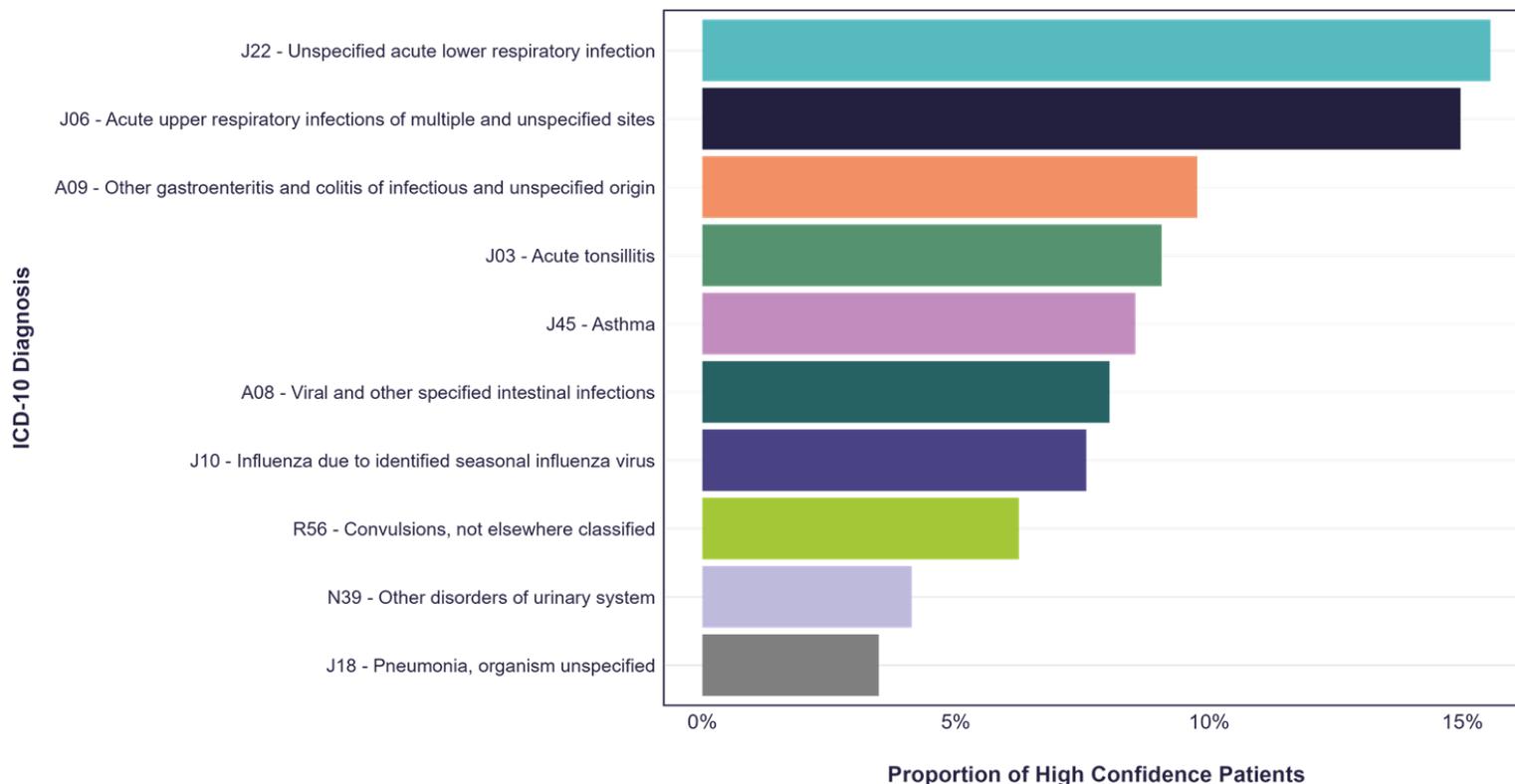
Since younger children have a higher proportion of admissions that may be divertible, it is worth exploring the specific conditions younger (ages 1-8) and older (ages 9-16) present with.

Given young children's large contribution to the overall cohort, it is not surprising that the primary diagnoses among them closely resemble those seen when age is not considered.

Volumes of divertible admissions, 9–16-year-olds (2024-2025)

## Top 10 Diagnoses - High Confidence (Ages 9–16)
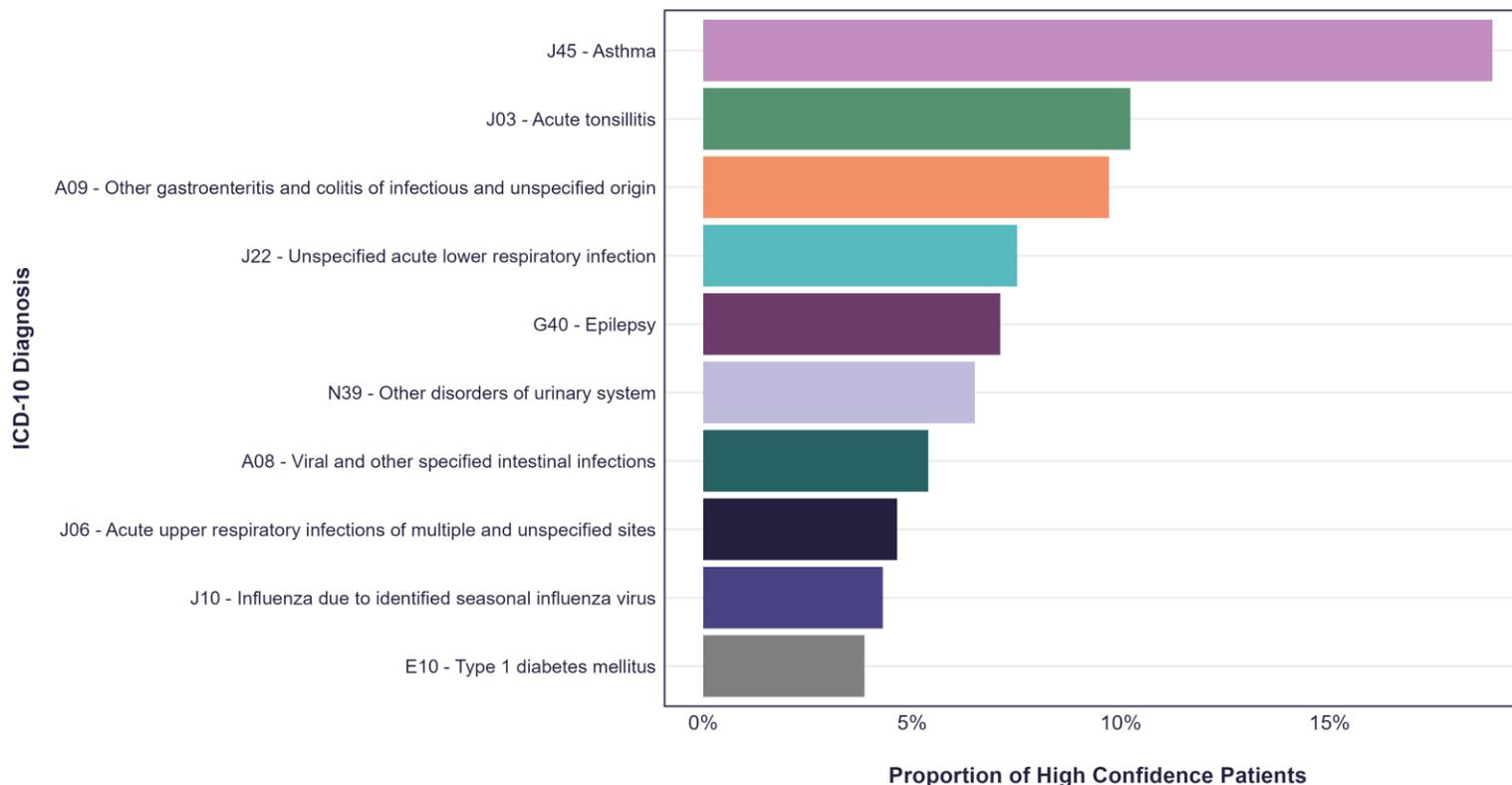
However, a closer look at older patients (ages 9-16) reveals a different pattern of most common diagnoses. Notably, asthma is the primary diagnosis for nearly 20% of high-confidence divertible patients.

The high prevalence of asthma among older divertible patients suggests that community-based asthma management programs could effectively reduce hospital visits for this group.
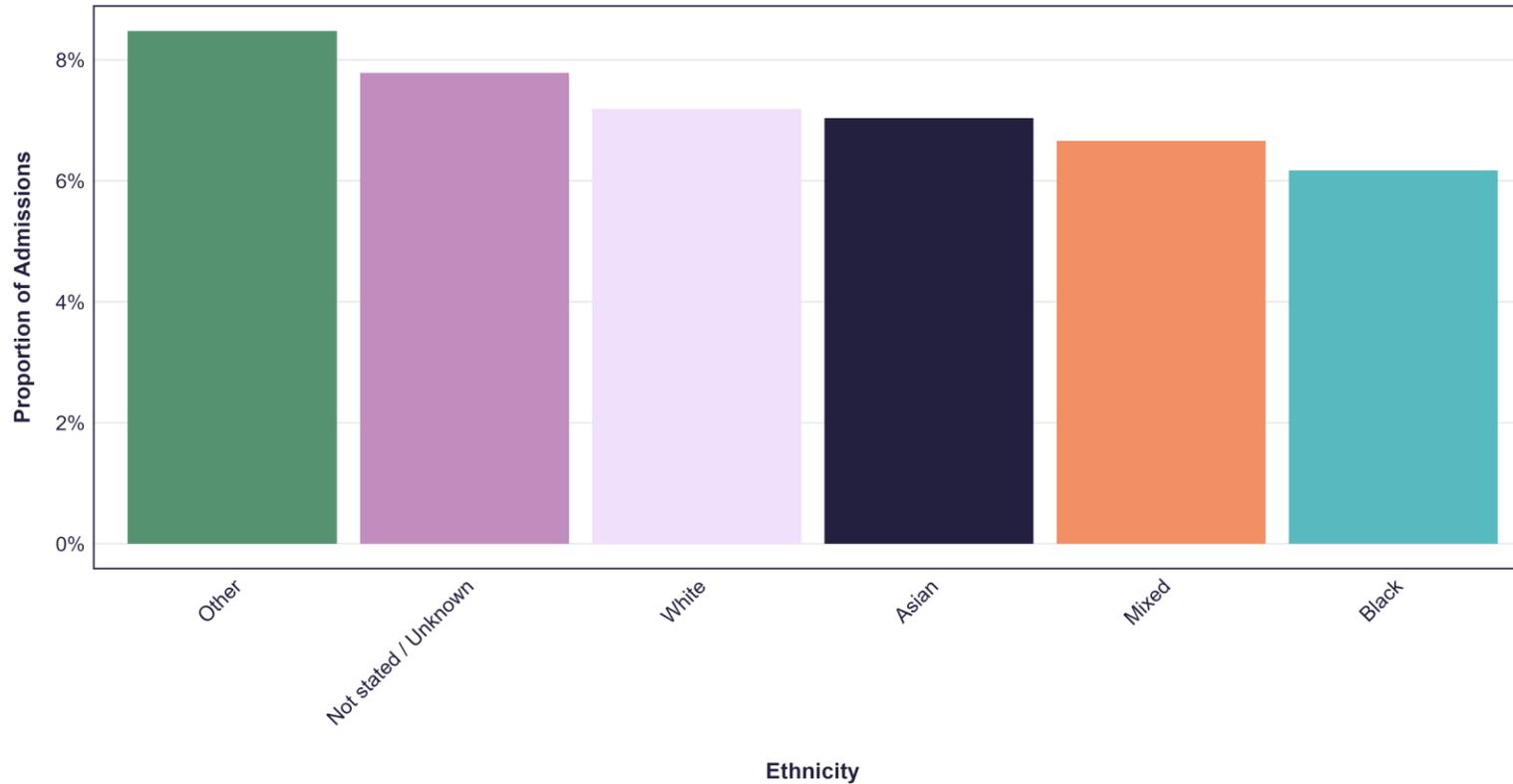
Demographic factors – sex

Proportion of divertible admissions within each sex - High Confidence
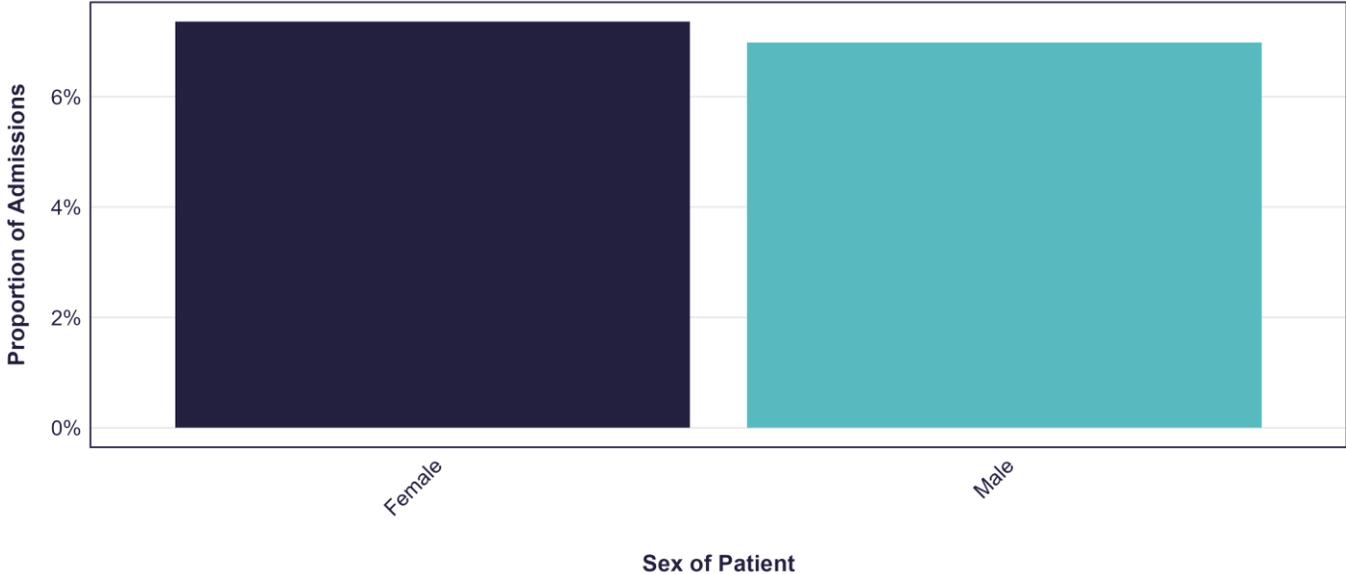
The sex of the patient does not appear to influence whether an admission is divertible.

Demographic factors – ethnicity

Proportion of divertible admissions within each ethnicity group - High Confidence

There appears to be no significant relationship here.

Definition: Variable costs

Cost Type
Blood and blood products
Blood and blood products (excluding High Blood Products)
Blood and blood products (including High Blood Products)
CNST payment
Devices implants and prostheses
Drugs
Drugs (excluding High Cost Drugs)
Drugs (including High Cost Drugs)
General Practitioners
High cost blood and factor products
High cost blood products
High cost drugs
Imaging
Medical Devices
Medical Devices To be used for all devices including those issued under MedTech Guidance
Multidisciplinary Meeting Coordinators
Patient support costs (Non Pay)
Patient support costs (Pay)
Pharmacy
Psychological therapists
Radioactive sources for internal radiotherapy
Supplies and services
Supplies and services - Non Patient Specific
Supplies and services - Patient Specific
Support costs

To accurately reflect costs associated with divertible admissions – as opposed to a hospital's running cost – we have considered variable costs and excluded fixed costs.

A summary of what was included as part of the variable costs' definition is summarised here.