Classification: Official

Publications approval reference: 001559

Changes to COVID-19 finance reporting and approval processes as we move into the second phase of the NHS response

19 May 2020, Version 1

Summary

The 29 April 2020 letter from Sir Simon Stevens and Amanda Pritchard to the NHS set out the approach to the second phase of the NHS's response to COVID-19.

This guidance outlines changes to the processes for reporting revenue expenditure and claiming reimbursement for capital expenditure related to COVID-19. This guidance is applicable to NHS trusts, NHS foundation trusts, CCGs, and NHS England direct commissioning.

For capital expenditure this replaces guidance issued on 27 March 2020 with effect from 19 May 2020. For revenue expenditure the principles within this guidance take effect from 1 May 2020, and for reporting purposes from Month 2.

COVID-19 additional revenue expenditure reporting

As we move into the second phase of the response, we expect that there will be changes in the areas where organisations are incurring necessary and additional COVID-19 expenditure.

Spend in some areas will be paused but may well be revisited if we experience a second wave of infections during this second phase.

In many areas we will expect spend to be markedly different to spend in March and April. The tables in Annex 1 outline in detail the areas of spend we might expect to see as we transition into phase two (including some areas where spend is expected to slow or stop). Month 2 COVID-19 reporting will align with these categories (although as the situation develops we will amend the reporting as required).

COVID-19 revised capital reimbursement claim process

The COVID-19 capital expenditure guidance issued 3 April 2020 included provision of a less than £250,000 category of capital investment which required only retrospective approval from the national capital team. This was designed to ensure that NHS trusts and foundation trusts could make timely capital investment to support the immediate COVID-19 response.

As we now commence financial planning for the second phase, we expect the number of urgent cases requiring immediate investment decisions to significantly decrease, therefore with effect from 19 May 2020, **all** COVID-19 cases requiring national PDC funding will require national pre-approval.

The turnaround time following receipt in the national COVID-19 capital team from regional team will be seven calendar days. In exceptional circumstances, for cases agreed as urgent by the NHS England and NHS Improvement regional director, we will continue to provide a 48-hour turnaround.

Future bids for COVID-19 capital investment should be made in the context of the revised capacity plans now being developed at regional and system level. All will need to be nationally approved prior to expenditure being undertaken to ensure that they will deliver infrastructure aligned to system, regional, and national capacity plans.

Any ‘less than £250,000’ COVID-19 capital claim forms not yet submitted by regional teams for payment will be processed on the same basis as the ‘greater than £250k’ bid forms and will be submitted to the national COVID-19 capital team for consideration of approval.

A single revised bid form template is now being issued for NHS trusts and foundation trusts to use which covers COVID-19 capital expenditure of all values. As you are aware, we are expecting regional teams to provide their second phase capacity plans on 18 May 2020 for consideration and agreement. Capital bids for investment in infrastructure to respond to second phase requirements will need to take account of those agreed capacity plans and will require the prior agreement of the regional director of finance in the context of the regional capacity plan before they are submitted for consideration.

Bids must be clearly and directly linked to these second phase capacity plans. Bids should also be necessary additional expenditure related directly to the COVID-19 response. Bids which do not meet these two criteria are unlikely to be approved.

Copies of the relevant claim form can be obtained from your regional contacts or by emailing england.nhscovidcapitalteam@nhs.net.

Further details on the process can be found in Annex 2.

Annex 1: Guidance on 2020/21 COVID-19 revenue cost reporting (second phase)

All tables included here represent the current situation and will change as we move through the second phase, particularly if there is a second wave of infections.

Table 1: COVID-19 policies, directives or nationally approved business cases

Category of spend	Guidance/link to policy	Direction of spend
Expand NHS workforce – medical/nursing/other	Ref: NHS invitation to return Ref: GMC statement (example for medics) Ref: NHS CNO letter (example for nurses) Costs relating to staff returning to work for the NHS. Costs relating to students fast-tracked to employment. Includes pay costs (with on costs) and additional induction costs if applicable. Include training costs and increased occupational health costs.	Likely to increase
Sick pay at full pay for all staff policy	Ref: Workforce guidance – Isolation NHS substantive/bank/sub-contractor staff who are self-isolating or sick due to COVID-19 to receive full pay for absence. This would also include spill-over into IS/third sector providers and ALBs.	Should decrease
COVID-19 virus testing (NHS laboratories)	Associated costs above existing resources for performing COVID-19 virus testing in line with published standard operating procedures, including phlebotomy for serology and additional administrative staff to support capacity.	Will increase
Remote management of patients	Ref: Important and urgent – next steps on NHS response to COVID-19 (17 March 2020) Support the provision of telephone-based or digital/video-based consultations and advice for outpatients, 111, and primary care. Revenue only.	Will increase
Support for stay at home models	Ref: Caring for people at highest risk during COVID-19 incident (21 March 2020) Costs associated with all patients who are considered to be at highest risk of severe illness that would require hospitalisation from COVID-19.	Likely to increase
Direct provision of isolation pod	Ref: Important and urgent – next steps on NHS response to COVID-19 (17 March 2020) It is expected that all costs of installing Pods or conversion of existing premises fell in 19/20. Expected that 20/21 costs will all relate to operationalising Pods and that costs will reduce as Pods are no longer required.	Decrease

Category of spend	Guidance/link to policy	Direction of spend
Plans to release bed capacity	Ref: Important and urgent – next steps on NHS response to COVID-19 (17 March 2020) Free up community hospital and intermediate care beds.	Should decrease / be replaced by hospital discharge programme
Increased ITU capacity (including hospital assisted respiratory support capacity, particularly mechanical ventilation)	Ref: Important and urgent – next steps on NHS response to COVID-19 (17 March 2020).	Maintain
Segregation of patient pathways	Ref: Important and urgent – next steps on NHS response to COVID-19 (17 March 2020) Segregate all patients with respiratory problems (including presumed COVID-19 patients).	Increase
Enhanced PTS	Ref: COVID-19 patient transport services: requirements & funding (27 March 2020).	Increase
Hospital discharge programme	Ref: COVID-19 hospital discharge service requirements (19 March 2020) CCGs to include spend relating to this guidance and to provide additional detail on separate worksheet within non-ISFE.	Increase
After care and support costs (community, mental health, primary care)	Ref: Important – for action – second phase of NHS response to COVID-19 (29 April 2020). Support for patients who have recovered from COVID-19 but need ongoing health support. Rehabilitation in the community. Support to 'shielding' patients. Mental health capacity and support.	Increase
Infection prevention and control training (community, mental health, primary care)	Ref: Important – for action – second phase of NHS response to COVID-19 (29 April 2020). Increased costs of training outside of the acute sector.	Maintain
Nightingale hospitals	Gross cost of Nightingale hospitals (setup and running costs).	Site dependent
Business Case (SDF) – Ageing Well – Urgent Response Accelerator	Specific SDF funding for Ageing Well – Urgent Response Accelerators that was deemed critical to the COVID-19 response. Costs relating to this funding should be included.	Increase
Business Case – GP – SMS (extension to contracts)	Costs relating to the agreement to fund the increased volumes of SMS text messaging capability in General Practice critical to support the COVID-19 response. This spend should only be incurred where approved by the regional team.	Increase but not exceed business case value

Table 2: Consequences of COVID-19

Category of spend	Guidance/link to policy	Direction of spend
Existing workforce – additional shifts to meet increased demand	Existing workforce meeting rising demand through additional shifts.	Decrease
Decontamination	The additional costs of decontamination as a result of COVID-19. This should not include the costs of all COVID-19 decontamination as it is expected that some element would fall within an organisation's usual costs.	Maintain
Infection prevention and control training (community, mental health, primary care)	Ref: Important – for action – second phase of NHS response to COVID-19 (29 April 2020).	Maintain
Internal and external communication costs	Relating to COVID-19.	Maintain
Backfill for higher sickness absence	The cost of additional shifts/agency or bank staff to cover higher sickness absence as a result of COVID-19.	Decrease
NHS 111 additional capacity	The costs of providing additional NHS111 surge capacity.	Decrease
Remote working for non-patient activities	The costs associated with enabling remote working for non-patient-related activities.	Decrease

Costs of nationally procured items/services

Where items or services are being procured and paid for nationally, they should not be included on the local returns. **However, if organisations have procured these items/services outside of the national process then they should be included and identified in the relevant column.**

A narrative explanation will be required for these costs (from Month 2 for providers). This list will be updated as we move through the second phase.

Table 3: Costs of nationally procured items/services

Category of spend	Guidance/link to policy
Personal protective equipment (PPE) Mechanical ventilators Bilevel/non-invasive ventilators CPAP devices Oxygen concentrators Video laryngoscopes – reusable and single use Bronchoscopes Ultrasounds Patient monitors CT scanners Mobile X-ray Portable suction pumps Enteral feed pumps (and associated consumables) Syringe drivers Volumetric pumps Blood gas analysers Continuous renal replacement therapy machines Ambulatory peritoneal dialysis machines Reverse osmosis machines	Department of Health and Social care and NHS letter to trust procurement directors – National procurement of critical supplies. Full list included for completeness. All items except for PPE should be charged to capital.
NHS staff accommodation – if bought outside of national process	NHS staff accommodation should be being procured via the national CTM system. Only include costs for any staff accommodation procured locally, outside of the national system.
Hotel accommodation – for step down beds	Step down beds in hotels should not be being commissioned locally. However, where local arrangements are in place these costs should be included and identified separately.

Annex 2: Submission and approval process for capital expenditure related to COVID-19

19 May 2020

NHS provider and CCG (2020/21) COVID-19 capital claims and bid process, effective 19 May 2020.

All bids must be clearly and directly linked to second phase capacity plans. Bids should also be necessary additional expenditure related directly to the COVID-19 response. Bids which do not meet these two criteria are unlikely to be approved.

Trusts, foundation trusts and CCGs may submit COVID-19 capital bid forms to regional finance as and when they are ready to seek approval. Applications will then go through a fast track process to secure national approval. In all but exceptional circumstances we will provide national approval within seven calendar days following confirmation of regional approval.

The bid template should be accompanied by sufficient backing information, including detail on:

- how the bid delivers against, and is aligned to second phase regional COVID-19 capacity plans
- precisely the capacity that is being provided to support those plans, eg bed numbers, type, location, and mobilisation date
- how it is intending to procure and operationalise the capacity
- any risks and issues to be managed
- confirmation that workforce implications of the new capacity have been or are being addressed sufficiently to ensure the operational viability of the investment.

All COVID-19 capital claims and bids will be reviewed by the COVID-19 capital finance team working closely with the COVID-19 revenue team in order to ensure there is no miscoding, double counting or omission.

Cashflow

Reimbursement of approved provider capital expenditure will take place via the established process for PDC allocations; however, this will be fast tracked. The process will include enacting PDC allocations, CDEL adjustments and subsequent capital cashflow. Once the memorandum of understanding is signed and returned, cash will be made available through the normal routes.

If any COVID-19 capital investment requires exceptionally fast cashflow for operational reasons, please escalate to your NHS England and NHS Improvement regional team and include the relevant explanation in the bid submission template.

Copies of the relevant claim form can be obtained from your regional contacts or by emailing england.nhscovidcapitalteam@nhs.net.

Questions

If you have any questions, please contact england.nhsCovidCapitalTeam@nhs.net.