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Approved Costing Guidance 2022: COVID-19 recommendations

Version 2, April 2022

Significant changes to the 2021 recommendations are highlighted in yellow.

This version includes references to the final version of the TAC schedules 2022.

Contents

Introduction 2

Costing recommendations 5

Information requirements 14

Appendix 1: Exceptional units and own patient care.................... 18

Appendix 2: Glossary.. 24

Introduction

1. The National Cost Collection (NCC) is a requirement of the provider licence, and providers need to make a cost submission that follows the Approved Costing Guidance (ACG). The NHS response to COVID-19 places significant pressures on the costing process, including difficulties tracing costs in the general ledger, a lack of capacity for clinical and service engagement, and the redeployment and unavailability of costing and informatics staff.

2. Given these pressures, for the collection of costs for the 2021/22 financial year, NHS England and NHS Improvement will accept a submission based on an amendment to the costing standards, where the amendment process has been clearly prioritised and where decisions about changed areas have been documented in the Integrated Costing Assurance Log (ICAL).[1]

3. This document focuses on the financial year 2021/22 for collection in 2022 for acute, mental health, community and ambulance services, plus any adjustments included in the Month 12 Audited Submission of the Provider Finance Return (PFR), which is used for the final accounts. Significant changes to the 2021 recommendations are highlighted in yellow. Thank you to everyone who contributed to this guidance.

4. Alongside this, we are publishing a summary of [key information and a recommendations checklist] on the Open Learning online learning platform (OLP).

5. **If changes to the final accounts templates or guidance impact the cost collection or this guidance, they will be covered in the frequently asked questions (FAQs) on the OLP**

6. The FAQ will include further information on the treatment of ~~virtual wards (added to the PFR at month 9) and~~[2] Nightingale hubs (added to the PFR at month 10).

[1] Please keep the documentation in the ICAL concise, so it does not itself become a burden.
[2] The virtual wards section in the PFR at M9 was removed in the M12 version.

7. Providers should continue to follow the costing principles of materiality, engagement and data and information, while retaining transparency and consistency throughout the costing process and reporting.

8. In parallel with the National Cost Collection, organisations submit specified incremental costs of COVID-19 services to NHS England and NHS Improvement as part of the regular monthly PFR, so these costs are known and validated monthly at the local level.

9. The final accounts will use the Month 12 Audited Submission of the PFR: this document should be used for the COVID-19 exclusions in the costing system and shown in the reconciliation.

10. For the patient-level and average cost per unit costing processes described below, we are recommending amendments to:

    - adjust the costing process to maintain reasonable data quality
    - understand reporting structures
    - treat exceptional costs consistently.

11. Recommendations are listed in this document as numbered action points. Where possible, existing costing standards, reporting structures and terminology are used. Action points are also listed in the accompanying COVID-19 Recommendations checklist2022 on the OLP as well as the FAQs.

12. Trusts should follow the collection guidance for the relevant sector. This includes submitting the relevant PLICS files (as mandated) and the National Cost Collection workbook for the rest of the services provided.

Our support offer

13. There are many ways to contact us and National Cost Collection partners for support in delivering these recommendations.

14. Please keep in contact by emailing costing@england.nhs.uk to ensure we understand your local situation, especially if you face significant difficulties.

15. We also offer:

    - one-on-one contact with providers through the ‘Coffee and Connect’ initiative
    - the facilitation of a peer-to-peer buddying scheme
    - costing standards and collection surgeries (at least three times weekly) to deal with specific provider queries, increasing to daily call surgeries during the collection window
    - the monthly Costing Newsletter
    - ‘Ask the Senior Leadership Team’ – a monthly opportunity to pose questions
    - regular webinars and costing learning sessions (CLS).

16. Frequently asked questions are posted on the Open Learning Platform weekly.

17. For detailed technical issues and all other queries, we offer email support at costing@england.nhs.uk

Costing recommendations

The costing process

18. The National Cost Collection 2020 COVID-19 recommendations gave a range of possible adjustments to process and exclusions from own patient care for the National Cost Collection. These were updated for the 2020/21 financial year to reflect minor changes to the structure of reporting COVID-19 costs in the PFR.

19. This document has been further updated with feedback from stakeholders, including themes taken from ICAL and other responses as part of the 2019/20 and 2020/21 National Cost collections.

20. The stakeholders have required that the National Cost Collection 2021/22 data should be prepared as accurately as possible and should **include the cost of own patient care** during the period impacted by COVID-19.

21. This cost, however, should not be inflated by the cost of national and regional units such as decommissioning the NHS Nightingale hospitals.

22. **There should not be any adjustment to the cost quantum for lost activity**.

23. The stakeholder feedback also produced the following findings:

    - The structure of the standards and collection is able to show resources and activities appropriate to the care given, and the ICD10 codes and new healthcare resource group (HRG) codes for COVID-19 can identify patients in acute (and in some community) providers. Therefore, there is no need to materially change the implementation of the standards or the collection.
    - The nature of the NHS response to COVID-19 (eg significant and sudden increases in ICU capacity, separation of patient care into COVID-19 and non-COVID-19 services, and ongoing care for the long-term impact) has impacted how costs are allocated and monitored by trusts. In particular, costing practitioners report that where resources are redeployed internally, the general ledger is not always updated in the usual way, including bank and agency spend not being aligned with the appropriate budget. This

means that costing practitioners may not have the underlying information needed to prepare precise patient-level costs.

- Clinical engagement and service manager input in costing remains limited, so the usual costing sense checks are less likely to be completed.
- Providers may have paused their annual costing plans for routine updates and developments, including delays to the work for the next year on the transition path.
- Cancellation of elective work will have increased the cost of remaining operations in theatres. The aggregate level, pseudonymised data dashboard from the exception quarterly collection has been published on the OLP and may be useful when trying to validate unusual changes in your unit price.
- In some trusts, COVID-19 cases did not immediately make use of redeployed resources, so they were underutilised (eg extra but unused critical care beds).
- Costing and information staff may have been or be off sick, isolating or redeployed to other areas.

24. The recommendations/actions (see paragraph 33 and following) should be prioritised and applied appropriately, with providers documenting that process. Factors in prioritisation are likely to include the availability of internal staff and software suppliers.

25. We also provide the recommendations on the OLP summarised as a checklist checklist.

26. The amended costing process decisions should be recorded in the template for COVID-19 amendments, now added to the ICAL. This does not need to be shared with us when costs are submitted for the 2021/22 National Cost Collection, but you should still retain this information for your governance process and for reference if your organisation is selected for a Costing Assurance Process (CAP) visit.

Exceptional expenditure

27. We recognise that expenditure on services has changed due to the COVID-19 pandemic. Where this expenditure relates to a provider's own patient care cost

group, they should be included in the cost of patient care, to show the cost of the current services.

28. There is, however, a type of expenditure that does not relate to a provider's own patient care and should not be included in the own patient care cost group. These 'exceptional units/services' should be reported as an exclusion in the National Cost Collection reconciliation statement regardless of how they have been reported in previous years.

29. The value of the exceptional units/services excluded should reconcile to the COVID-19 tabs in the Month 12 Audited Submission of the PFR 2021/22. The tabs required for the reconciliation are named:

    - 10a1. COVID_19 In Envelope
    - 10a2. COVID_19 Outside Envelope
    - ~~10a4. COVID_19 Nightingale Testing~~
    - 10a3 Nightingale hubs (PFR codes now available in Appendix 1)
    - 10c. Independent Sector spend (see section on 'part costs' below)

30. On the PFR tabs, both types of expenditure to support the pandemic service changes are shown. We have defined the costs on these tabs as exceptional units/services or own patient care costs. The two groups are separated in Appendix 1,[3] so the cost of the organisation's own patient care can be clear, and not inflated by the cost of caring for other patients.

31. Exceptional units/services should be reported as an authorised adjustment in the National Cost Collection reconciliation as part of the expenditure value on line OEADJ07 Final Accounts - FAQ Adjustment 1. The income relating to COVID-19 services will be shown on line OEADJ08 Final Accounts - FAQ Adjustment 2.

32. The exceptional units/services costs shown in Appendix 1 and as reported on the COVID-19 tabs of the PFR include:

    - decommissioning of COVID-19 services and the establishment of Nightingale hubs

[3] Please note: Appendix 1 has been updated to follow changes to the 2021/22 M6 PFR. There may be further changes for the M12 PFR.

- National COVID-19 laboratory testing centres, and regional/local pathology hubs providing tests for mental health and community trusts, care homes and other individuals[4]
- 111 additional capacity
- vaccination services
- costs supporting other organisations' COVID-19 services, including infection prevention and control training in community, mental health and primary care trusts
- Direct provision of isolation pods, and Aging Well
- international quarantine costs.

33. These costs should not form part of the reported costs of own patient care in the National Cost Collection. Activity recorded on these units should also be excluded.

Action 1: The cost of COVID-19 exceptional units/services should be excluded from the NCC cost quantum for 'own patient care'. The value excluded should be the value reported on the COVID-19 tabs of the 2021/22 Month 12 Audited Submission PFR.

This value will need to be calculated using the categories shown in Appendix 1 and should be entered on a local copy of the Spreadsheet: quantum reconciliation template - analysis B and the total for COVID-19 excluded services shown on the NCC reconciliation using line OEADJ07 Final Accounts - FAQ Adjustment 1[5]. The separate values of exceptional units/services should be shown in the Analysis B using the itemised PFR code values, and this should be retained for reference.

Where the income for the exceptional units/services has been included as 'other operating income' in the final accounts, it will show in Line 2 of the reconciliation. You should show the income value for the COVID-19 services on adjustment line OEADJ08 Final Accounts - FAQ Adjustment 2, and not adjust line 2.

[4] In the same way as direct access, these individuals are not under the clinical responsibility of the trust beyond the test itself.
[5] Line number OEADJ07 Final Accounts - FAQ Adjustment 1

34. Providers should not apply additional overheads to the costs excluded for exceptional units or services if they were not included in the PFR for final accounts.

Action 2: Briefly document the cost reconciliation process for COVID-19 cost and income in the ICAL for your own reference. This information does not need submission with the NCC for 2021/22.

Unusual additional expenditure or accounting treatments

35. There may have been changes to the general ledger location for the financial year 2021/22. You should review the process you usually use for the final accounts reconciliation to identify expenditure and income correctly.

36. You should also work with your finance team to understand any unusual treatment of costs or income in the general ledger. For example, where income has been offset against costs to show the net effect in the final accounts, you should understand how this is shown in your NCC reconciliation statement.

Adjusting for 'part costs'

37. Where items have been purchased by regional or central procurement hubs, where service costs have been shared across providers, or where your trust is the hub for items dispatched to other organisations, the total cost of care may not be shown in the trust, and therefore you are unable to submit the full cost of these patient events in the NCC.

38. Where you have the cost and activity of the care of your own patient care cost group, but not the material running costs of equipment such as respirators[6] etc You may flag part costs within the own patient care cost group in the national cost collection, as these would provide an inappropriate cost per patient event.

39. Where you have cost but no activity, please refer to the NCC guidance Volume 2 section 5.1: Services supplied and received: provider to provider (P2P).

40. You should retain evidence of these costs in your ICAL for review by the costing assurance programme.

41. Independent sector providers (ISP) were not centrally commissioned to provide care during 2021/22, therefore you do not need to adjust the cost. Any ISP costs in your final accounts relate to your organisation's own patient care.

42. Retain the process and detail of values for all these calculations, as this will be reviewed in the Costing Assurance Programme. Information evidencing the calculation for the exclusion on these lines will be subject to Costing Assurance Programme review.

Action 3: Understand any change to the final accounts process and locations in the general ledger and identify any unusual treatments of costs or income in the general ledger, including provider-to-provider adjustments. You should ensure these items are treated appropriately in the costing system and the NCC reconciliation.

Costing 'own patient care'

43. The own patient care cost quantum should include:
    - costs of own patient care included on the COVID-19 tabs of the PFR, shown as 'own patient care' in Appendix 1
    - COVID-19 costs not reported on the PFR.

44. We appreciate that trusts may have different information available when allocating additional costs and minimal time with the service leaders will be available to complete the verification of these allocations. This may lead to data quality issues and this will be considered when using the information produced.

45. The following actions may require significant additional work and it is recommended that only the most important to your organisation are prioritised. As part of that prioritisation exercise, consider the availability of clinical and operational staff in your organisation and the amount of support your software supplier can offer.

Action 4: Allocate COVID-19 costs using a locally agreed allocation method. Some adjustments will require costs to be allocated across all patients rather than just COVID-19 patients, and other costs are specific to COVID-19 patients. Suggestions for appropriate allocation methods for the items

included in the PFR are shown in Appendix 1. If COVID-19 patients cannot be identified separately from other patients, all patients should be included.[7]

For example, clearly identifiable COVID-19 costs for the emergency department can be allocated against all patient events, as all patient events will be suspected COVID-19 until status is confirmed.[8]

46. Costing existing service areas may also need some adjustment to ensure a ‘reasonable’ cost is achieved.

Action 5: Costs for all types of medical staff can be allocated across all patients in the relevant ward in the appropriate month, without the need for ward-round data at patient level. Medical HR departments or e-rostering are a source of redeployment information in many trusts. Record any assumptions where relevant weight values have been used rather than ward round data in your ICAL. We recognise this action may need input from service managers or clinicians, but a high-level approach may be taken.

For example: As part of the pandemic response in your organisation, consultants in a specialty may have been redeployed to support COVID-19 wards during month X but there is no information recording how many consultants. In this instance, you could use a formulaic approach to calculate the proportional change in actual activity as a proxy for the number of consultants redeployed by applying the percentage change in activity to the total number of consultants in that specialty[9] The formula to calculate that change is:

$$1 - (\text{actual activity}/\text{expected activity})$$

Action 6: Staffing expenditure may have been moved to support front line or COVID-19 specific areas. Check with the financial management team, or e-rostering systems for material changes, to ensure the costs in the general ledger go to the correct service areas. If no current information is available, use estimates and document your assumptions.

[7] This is to cover the additional costs for infection control in all services and is irrespective of the separate service areas established for suspected COVID-19 patients.
[8] Please note, this will not include COVID-19 costs if they have been excluded as an exceptional unit/service cost in action 1.
[9] Worked examples of this can be found on the Open Learning Platform.

You may need to disaggregate some costing account codes, but only do this where the cost is material. If new roles cannot easily be matched within the CP2.1 cost ledger, please refer to the Resource Application Hierarchy tool, to ensure the cost flows to the appropriate resource.

Action 7: For clinical non-pay items check that the additional material expenditure is allocated to the correct service areas. Expenditure in March for use in April should have been adjusted for in the general ledger so should not have a significant balance remaining in year.

Action 8: Estates and facilities costs should be adjusted for local information, where available. For areas that have been redeployed, separate floor area allocation relative weight value tables could be established; one for the COVID-19 services support months and then a separate configuration at month when the redeployment happened.

47. Where an organisation currently has a 'year to date' costing model, we appreciate that time periods cannot be separately identified for reviews of allocation methods; for example, where medical staff plans have changed several times during the year. You should decide locally the best way to reflect the changes in cost in the costing system.

48. We expect providers will wish to review other areas but will not be able to do so due to pressures of time and resources. In these circumstances we recommend you focus on the areas that will have the greatest impact.

49. We recognise that the cost of staff in isolation or taking exceptional annual leave is significant for some trusts. These costs should be included in the relevant cost group.

Information changes

Action 9: Identify where theatres, recovery units or general wards have been turned into critical care capacity. Understand if your organisation is recording the episodes on the Critical Care Minimum Dataset. Providers should match the cost associated with those new critical care areas and the associated episodes to submit the patient events in the correct part of the NCC.

Action 10: Identify any changes to estates in your organisation, eg creation of a new ward from theatres. Ensure the new ward and the associated episodes are included on your admitted patient care feed or ward stay feed so they flow into the PLICS information for your organisation.

Action 11: Identify new non face-to-face (telemedicine) activity being recorded in the patient administration system (PAS) and ensure they are being captured in non-admitted patient care feed so they into the PLICS information for your organisation.

Internal assurance process

50. It is still important to maintain an assurance process, although we accept this will be a 'lighter touch' than prior to the pandemic. We recommend recording changes and assumptions in the ICAL. For this year we will not require a board level assurance process; instead the National Cost Collection can be signed off by the director of finance. Items marked by ** in Appendix 1 should be included in the signoff process, whether they were prioritised locally or not.

51. We expect trusts to do what they can to facilitate a reasonable cost submission. Where costing practitioners identify areas of their submission which they do not consider 'reasonable', but which are included as part of the provider's National Cost Collection, these should be recorded in the ICAL and noted in the director of finance sign off sheet.

52. We will review the costing assessment tool and the Costing Assurance Programme to ensure that they are relevant to the costing process and collection during the COVID-19 outbreak. Items on year 3 of the transition path (Acute) were moved to year 4 but will now be considered part of the mandated collection. (Items in years 4 and 5 were also moved on a year. Please see the integrated trusts costing transition path)

Information requirements

53. It is important for every trust to track COVID-19 to ensure the patient record is complete.

54. The World Health Organization has allocated six flexible ICD10 codes to enable effective reporting:[10]

    - U07.1: to track patients confirmed with the COVID-19 virus
    - U07.2: for those suspected but without confirmed diagnosis
    - U08: personal history of COVID-19
    - U09: post COVID-19 condition
    - U11: need for immunization against COVID-19
    - U12: adverse reaction to COVID-19 vaccine.

55. These codes were made available to the clinical coders via special updates to the clinical coding guidance, so should be available in the PAS structure (although we appreciate that not all trusts have clinical coders). These codes can be applied by other staff if this local rule is ratified by a clinical coder.

56. There are also many SNOMED-CT codes[11] that can be used as an alternative in any sector, including:

    - 1240751000000100 | Coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 (disorder)[12]
    - 1240761000000102 | Suspected coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 (situation).

[10] https://www.who.int/standards/classifications/classification-of-diseases/emergency-use-icd-codes-for-covid-19-disease-outbreak These codes will be used in conjunction with other condition and intervention codes, to provide the complete view of the coded record. For more information please contact your local clinical coders.
[11] https://termbrowser.nhs.uk/?
[12] The SNOMED-CT browser can be accessed here. You should search for required information by searching on the name or code of the condition.

57. All sectors can use these codes as identifiers. They should be used where possible to provide trusts with local information on COVID-19. The table below outlines what data should be available in each sector.

Table 1 Data available in the different sectors

Sector	National coding
Acute	ICD10 code U07.1 and U07.2. These can be applied to all relevant patient events. Either of these codes may be the primary diagnosis, but they may also occur in a second or subsequent position. Spreadsheet IR1.2 in the technical document does not require secondary diagnoses, so check whether your costing system can identify them to enable complete reporting. A&E systems should now be using the SNOMED-CT codes as part of the Emergency Care Data Set, including the COVID-19 codes shown above.
Ambulance	ICD10 codes and SNOMED-CT codes are not recorded in CAD systems and therefore COVID-19 incidents cannot be tracked using ICD10 codes. Discuss with NHS England and NHS Improvement if: • the call system shows an identifier for 'suspected COVID-19' can be linked to the incidents locally, or • if there is alternative local code which can be used to identify patients.
Community	Admitted patient care: use the ICD10 codes listed as these are used in the Commissioning Data Set. Community care contacts: your organisation should record either the ICD10 or SNOMED-CT codes in your patient data, as they are part of the CSDS table CYP608 SecDiag (Secondary Diagnosis).[13] This will

[13] The data item is mandatory in the MHSDS - M605010 SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY) https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/tools-and-guidance

Sector	National coding
	allow you to track the cases locally. Spreadsheet IR1.2 in the technical document requires secondary diagnoses.
Mental health	Record either the ICD10 codes or the SNOMED-CT codes in your patient data, as it is part of the MHSDS table MHS605 SecDiag (Secondary Diagnosis).[14] This will allow you to track the cases locally. Spreadsheet IR1.2 in the technical document does not require secondary diagnoses, so check whether your costing system can identify them to enable complete reporting.

Critical care

58. The HRGs for critical care do not separately identify which patients had COVID-19, therefore if local reporting is required on this topic, you would need to link the critical care record to the clinical coding of the core episode.

Healthcare resource groups

59. The NHS Digital National Casemix Office has created a new costing grouper for 2021/22, which includes a new subchapter DX COVID-19 Infection. This includes six new HRGs for patients of all ages with a primary diagnosis of either test positive or clinically determined COVID-19, and no significant procedure(s). These changes were made to the Local Payment Grouper 2020/21 and the 2020/21 Costing Grouper, and will be included in the grouper updates for 2021/22.

60. More information and the technical output specification are available at: https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools.

Non-admitted patient care

[14] The data item is mandatory in the MHSDS - M605010 SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY).

61. Outpatient appointments rarely have a diagnosis code recorded, so it is unlikely that COVID-19 can be tracked using ICD10 or SNOMED-CT coding for outpatients, and there are no COVID-19 specific HRGs applicable to non-admitted patient care.

62. As all organisations should know which patients were suspected or confirmed COVID-19 patients, it may be possible to track them from a locally held list or the clinical coding. Please note we do not require this mapping as a part of the mandated costing process, and recognise it is not the costing practitioner's responsibility to maintain lists of COVID-19 patients.

Action 12: Clinical coding/other referencing of COVID-19 patients. we recommend practitioners continue to work with clinical coders, informatics leads and software suppliers to ensure these codes are included in the PAS and in the feeds to PLICS for local reporting.

Collection requirements 2022 (FY2021/22)

63. We can access the ICD10 codes for acute trusts via the National Cost Collection matching process with Hospital Episode Statistics data. We are therefore not collecting the ICD10, SNOMED-CT or other identifier for COVID-19 in the 2021/22 National Cost Collection (NCC). This means there has been no change to the extract specification relating to COVID-19 coding.

64. For the 2022 National Cost Collection, all provider organisations will be submitting patient-level costs. Please refer to the PLICS extract specification for your sector for detail on the output files required.

Appendix 1: Exceptional units and own patient care

This table shows the detail of the NHS England and NHS Improvement Provider Finance Return tab relating to COVID-19 costs. It defines for costing the treatment of these costs as either exceptional unit/service (excluded on line OEADJ07 Final Accounts - FAQ Adjustment 1 of the reconciliation statement) or included cost (treated as own patient care). This table is also available in excel format on the OLP.

Please note: this table is included for information. You should not seek to exclude any costs that were not reported to NHS England and NHS Improvement if they are not materially affecting the data quality of your organisation's output.

Rows shown in grey were retired for M12. These rows were shown in the version published on 1st March 2022.

New	PFR tab	PFR code	Allowable cost type Item	PFR row	Costing definition	Guidance	Allocation method	Column on PFR tab
	10a1	10ACOV7	Expand NHS workforce: medical/nursing /allied health professionals/healthcare scientists/other	Row 46	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all patient events	M
	10a1	10ACOV8	Additional Sick pay at full pay for all staff policy - full pay for COVID-related staff absence (for those not normally entitled to sick pay)	Row 46	Own patient care	Include in cost quantum		N
	10a1	10ACOV18	Existing workforce additional shifts to meet increased demand	Row 46	Own patient care	Include in cost quantum		O
	10a1	10ACOV20	Backfill for higher sickness absence	Row 46	Own patient care	Include in cost quantum		P
New	10a1	10ACOV59	NHS Staff Accommodation - if bought outside of national process	Row 46	Own patient care	Include in cost quantum		R
New	10a1	10ACOV60	PPE - locally procured	Row 46	Own patient care	Include in cost quantum		S
Moved from 10a4	10a1	10ACOV2	Other COVID-19 virus/antibody (serology) testing (not included elsewhere)	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	T
New	10a1	10ACOV68	NIHR SIREN testing - M1-M6	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	U
New	10a1	10ACOV65	Lateral Flow Antigen Testing	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	V
Moved from 10a4	10a1	10ACOV66	LAMP testing	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	W
Moved from 10a4	10a1	10ACOV67	Lighthouse Laboratories and amplitude labs - Pillar 2 testing	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	X

New	10a1	10ACOV54	COVID-19 virus testing - Rapid Testing – locally procured devices post 1 Sept 2020	Row 46	Own patient care	Include in cost quantum	Allocate across all patient events	Y
	10a1	10ACOV61	PPE associated costs	Row 46	Own patient care	Include in cost quantum	Allocate across all patient events	Z
	10a1	10ACOV14	Increase ITU capacity (including increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	Row 46	Own patient care	Include in cost quantum	Allocate across all ITU/ICU patients	AA
	10a1	10ACOV10	Remote management of patients	Row 46	Own patient care	Include in cost quantum	Allocate across all non-admitted patient care, including non-face to face contacts	AB
	10a1	10ACOV11	Support for stay at home models	Row 46	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all patient events	AC
	10a1	10ACOV15	Segregation of patient pathways	Row 46	Own patient care	Include in cost quantum		AD
New	10a1	10ACOV13	Plans to release bed capacity	Row 46	Own patient care	Include in cost quantum		AE
	10a1	10ACOV19	Decontamination	Row 46	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all patients	AF
	10a1	10ACOV62	Ambulance capacity	Row 46	Own patient care	Include in cost quantum	Allocate across all journeys	AG
	10a1	10ACOV16	Additional PTS costs	Row 46	Own patient care	Include in cost quantum	Allocate across all patient transport service journeys	AH
	10a1	10ACOV21	NHS 111 additional capacity	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	AI
	10a1	10ACOV4	After care and support costs (community, mental health, primary care)	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	AJ

	10a1	10ACOV5	Infection prevention and control training (community, mental health, primary care and acute)	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	AK
	10a1	10ACOV22	Remote working for non-patient activities	Row 46	Own patient care	Include in cost quantum	Allocate across all patient events	AL
New	10a1	10ACOV6	Internal and external communication costs	Row 46	Own patient care	Include in cost quantum	Allocate across all patient events	AM
New	10a1	10ACOV17	Business Case (SDF) - Ageing Well - Urgent Response Accelerator	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	AN
New	10a1	10ACOV12	Direct Provision of Isolation Pod	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	AO
New	10a1	10ACOV63	PPN and other support to suppliers	Row 46	Own patient care	Include in cost quantum	Allocate across all patient events	AP
New	10a1	10ACOV24	Other	Row 46	Own patient care	Include in cost quantum	Allocate across all patient events	AQ
Moved from 10a4	10a2	10ACOV69	COVID-19 virus testing - rt-PCR virus testing	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	G
New	10a2	10ACOV3	COVID-19 virus testing - Antibody testing for social care staff	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	H
Moved from 10a4	10a2	10ACOV275	COVID-19 virus testing - Rapid/point of care testing (for DHSC provided Samba2, DNA Nudge, Primer Design, LumiraDx and Abbott ID NOW)	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	I
New	10a2	10ACOV260	COVID-19 virus testing - decommissioning costs (reimbursable programmes only)	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	K
	10a2	10ACOV215	COVID-19 - Vaccination Programme - Vaccine centres	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	L

	10a2	10ACOV225	COVID-19 - Vaccination Programme - Provider/hospital hubs	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	M
	10a2	10ACOV230	COVID-19 - Vaccination Programme - Local vaccination service	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	N
	10a2	10ACOV235	COVID-19 - Vaccination Programme - Lead employer	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	O
	10a2	10ACOV265	COVID-19 - Vaccination Programme - vaccination site decommissioning costs	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	P
	10a2	10ACOV240	COVID-19 - Deployment of final year student nurses	Row 46	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all admissions	Q
New	10a2	10ACOV250	COVID-19 - repatriation costs	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	R
	10a2	10ACOV255	COVID-19 - International quarantine costs	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	S
	10a2	10ACOV245	COVID-19 - Seacole Centre Headley Court	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	T
	10a3	10ACOV304	COVID-19 Nightingale Total (Incremental)	Row 46	Exceptional unit/service	Exclude from cost quantum	n/a	M
Retired	10a4	10ACOV320	COVID-19 virus testing - rt-PCR virus testing - locally procured reagents	Row 62	Exceptional unit/service	Exclude from cost quantum	n/a	
Retired	10a4	10ACOV325	COVID-19 virus testing - Rapid/point of care testing - locally procured reagents costs	Row 62	Exceptional unit/service	Exclude from cost quantum	n/a	
Retired	10a4	10ACOV330	COVID-19 virus testing - Rapid/point of care testing - all other locally procured devices	Row 62	Exceptional unit/service	Exclude from cost quantum	n/a	
Retired	10a4	10ACOV335	NIHR SIREN testing - research staff costs	Row 62	Exceptional unit/service	Exclude from cost quantum	n/a	

	10a4	10ACOV220	NIHR SIREN testing - antibody testing only	Row 62	Exceptional unit/service	Exclude from cost quantum	n/a	
Retired	10a4	10ACOV340	Antibody Assays	Row 62	Exceptional unit/service	Exclude from cost quantum	n/a	
Retired	10a1	10ACOV55	Long COVID	Row 46	Own patient care	Include in cost quantum	Allocate according to Costing Process standards. These patients should be within the trust activity.	

Appendix 2: Glossary

This summary works with the main Costing glossary. These terms relate specifically to the impact of the COVID-19 pandemic.

Term	Definition
COVID-19 outbreak	The period during which the COVID-19 virus impacted those in the UK and the healthcare services. Dated from March 2020, and at the time of publication the impact was still ongoing.
COVID-19 patient	A patient clinically coded as either confirmed with the virus or suspected of having COVID-19. Once the coding no longer codes them as confirmed or suspected, they are no longer classified as COVID-19 for costing purposes.
Exceptional service/unit	A service set up specifically for the COVID-19 outbreak (Nightingale units) and not relating to the organisation's own patient care (even if these units were subsequently used for non-COVID-19 patients). Or A trust service such as pathology laboratories providing COVID-19 testing for patients not considered 'own patient care', eg care homes, mental health and community trusts. Patients seen by these services are not part of the 'normal' commissioned patient services outside the COVID-19 work. The service is usually funded centrally outside normal commissioner or provider-to-provider contracts. The cost must have been included in the PFR during 2021/22.
Pandemic	A pandemic is the worldwide spread of a new disease.
Provider finance return (PFR)	The monthly finance return submitted by trusts and foundation trusts to NHS England and NHS Improvement Finance Department
Relaxation of the costing standards	We are not removing the need to follow the costing standards but accept that the COVID-19 outbreak has required a more flexible approach. For the 2021/22 financial year, we are allowing trusts to decide where they need to reduce compliance to the standards to enable a reasonable cost output. All such decisions should be documented in the ICAL, to maintain appropriate governance.

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