National Cost Collection 2021 COVID-19 Recommendations

Recommendations for the implementation of costing standards for financial year 2020/21 as a result of the impact of the COVID-19 pandemic in England.

Contents

Executive Summary

Key recommendations for costing for financial year 2020/21

1. There have been significant national changes to operational and clinical practices as a result of the COVID-19 pandemic. This document updates recommendations issued in 2020 and should be used for the National Cost Collection return for the 2020/21 financial year.

2. Unlike last year, we are collecting the vast majority of costs relating to COVID-19 for providers' own patient care, to improve understanding of the impact of the pandemic on COVID-19 related and non-COVID-19 related care.

3. This document shows the areas where the costing standards can be amended for the financial year 2020/21[1] in light of the impact of the COVID-19 pandemic on NHS services. It also contains additional collection guidance related to specific COVID-19 services.

4. This document contains recommendations enabling organisations to improve the understanding and data quality of their local data and the National Cost Collection. Organisations should take steps to achieve a reasonable submission of data.

5. The three key messages continue. These are:

    - prioritise the recommendations locally
    - act on the priorities agreed locally
    - document what you have done.

6. These recommendations are intended to support costing practitioners' continued implementation of the Approved Costing Guidance. They will also provide useful explanatory notes for the other teams who are part of the costing process within your organisation.

7. NHS England and NHS Improvement recommends that costing practitioners should prioritise these recommendations with their local stakeholders, adjust

[1] Collection in 2021 for acute, mental health, ambulance & community services.

their costing processes accordingly and administer any changes in collecting and reporting costs. It is not expected that trusts will necessarily make all the recommended changes. In addition, it is recognised that pressures on software suppliers means that they will not be able to support all the changes in all the trusts.

8. Costing practitioners should utilise this document alongside the existing published documentation to prepare the appropriate information for their organisation. These recommendations are made in accordance with the NHS Costing Principles[2] of materiality, engagement and data & information.

9. **These recommendations are NOT the same as the 2019/20 recommendations.**

10. The four key recommendations are:

    - Exceptional units (such as the Nightingale units) should not be included in the National Cost Collection except as a reconciling item (see definitions in paragraph 40 and the glossary at Appendix 4).
    - Methods to amend the mandated standards which allow a lower level of data quality proportional to the circumstances created by the response to COVID-19.
    - Decisions about, and prioritisation of, the recommendations in this document should be recorded in the Integrated Costing Assurance Log (ICAL). The ICAL does not need to be submitted with the NCC return for 2020/21.
    - There are no specific changes to the collection files for 2021 to capture the specific costs of COVID-19 patients[3].

11. At present there is no requirement for organisations to undertake a separate patient-level or aggregate cost collection for COVID-19 patients for the financial year 2020/21 for collection in 2021[4].

[2] https://www.england.nhs.uk/approved-costing-guidance/
[3] See Financial Year 2020/21 in executive summary.
[4] However all provider organisations should continue to comply with the requests for information on COVID-19 expenditure (not costs) from NHS England and NHS Improvement, including those as part of the PFR return.

12. The requirements for the output produced for the National Cost Collection will not be affected by the impact of COVID-19. As such, that output will continue to rely on the data available in providers' systems, including:

    - Clinical coding for **acute and community services** using specified ICD10 codes.
    - Local information that uses the call system to identify COVID-19 patient events and then links this to the incident for **ambulance services**.
    - For **mental health services** the mandated Mental Health Services Dataset has a field for secondary diagnosis and will use either ICD10 or SNOMED-CT codes. If it is not available, a local identification of COVID-19 patients would be expected for clinical and operational reasons, so this should be used to identify patient events in PLICS.
    - In addition, the new Casemix Grouper will include a range of COVID-19 specific HRGs for hospital services.

13. Despite these recommendations, the recording and reporting of accurate cost information remains a requirement of the NHS provider licences. This means that the mandated standards still apply. Therefore, your costing teams should enlist senior support to help ensure that costing information that is produced remains of the required standard.

14. In addition to producing these recommendations, other actions NHS England and NHS Improvement is taking include:

    - Exploring what is required for the national PLICS Portal, dashboards and publications for 2020/21 in terms of differentiating between COVID-19 and non COVID-19 episodes and attendances to enable providers to understand the data quality in the National Cost Collection submissions of their own and of other organisations.
    - Reviewing the Costing Assurance Tool (CAT) and Costing Assurance Programme (CAP) to ensure they are proportionate to the NHS response to COVID-19.
    - Increasing support for costing practitioners to help implement these recommendations. Details can be found in Appendix 1.

Introduction

15. The National Cost Collection is a requirement of the provider license and providers should make a cost submission that follows the Approved Costing Guidance. 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.

16. In view of these pressures, for the collection of costs for the 2020/21 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)[5].

17. This document focuses on financial year 2020/21 for collection in 2021 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.[6]

18. **If there are changes to the final accounts templates or guidance, which impact the cost collection, they will be shown in the Frequently Asked Questions (FAQ) on the online learning platform[7].**

19. Providers should continue to follow the costing principles. These are materiality, engagement and data & information, whilst retaining transparency and consistency throughout the costing process and reporting.

20. In parallel with the National Cost Collection, organisations are submitting 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 local level.

[5] Please keep the documentation in the ICAL concise, so it does not become a burden in itself.
[6] There may need to be an update to this guidance following the final issue of the financial accounts structure. You should watch the cost collection Frequently Asked Questions (FAQ) on the online learning platform for updates.
[7] https://www.openlearning.com/nhs/courses/costing-improvement/faqs/?cl=1

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

22. For the patient-level and average costing processes described below, NHS England and NHS Improvement are recommending amendments to:

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

23. Recommendations are listed in this document as numbered action points. Where possible, existing costing standards, reporting structures and terminology are used (see Appendix 4 for a glossary of terms). Action points are also listed in the checklist in Appendix 2.

24. 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 remainder of services provided.

25. Please note: this guidance may need to be updated following the final accounts guidance release.

Support available from NHS England and NHS Improvement

26. A flowchart is included in Appendix 1 to indicate suitable ways to contact NHS England and NHS Improvement and the National Cost Collection partners for support in delivering the recommendations in this document and the National Cost Collection.

27. Please keep in contact by emailing costing@improvement.nhs.uk to ensure that NHS England and NHS Improvement understand your local situation, especially if facing significant difficulties.

28. Further support provided by NHS England and NHS Improvement includes:

    - one-on-one contact with providers through the ‘Coffee and Connect’ scheme
    - the facilitation of a peer-to-peer buddying scheme

- the holding of weekly costing standards and collection surgeries to deal with specific provider queries, increasing to daily call surgeries during the collection window.

29. Frequently asked questions are posted on the Open Learning Platform weekly[8].

30. For detailed technical issues and all other queries, NHS England and NHS Improvement offer email support costing@improvement.nhs.uk

[8] https://www.openlearning.com/nhs/courses/costing-improvement/faqs/

Costing Recommendations

The Costing Process

31. NHS England and NHS Improvement reviewed the structure of the costing standards and consulted with costing practitioners and other stakeholders on costing practicality for the 2019/20 financial year. 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.

32. This document has been updated for further feedback from stakeholders, including themes taken from ICAL responses as part of the 2019/20 NCC. We thank all those who contributed to providing this guidance.

33. The stakeholders have required that the national cost collection 2020/21 data should be prepared as accurately as possible and should **include the cost of own patient care** during the period impacted by COVID-19.

34. This cost however, should not be inflated by the cost of patients seen at the national and regional units such as Nightingale Hospitals.

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

36. The stakeholder feedback produced the following findings:

    - The structure of the standards and collection is able to identify resources and activities appropriate to the care given, and the ICD10 codes and new HRG codes for COVID-19 can identify patients in acute (and in some community) providers. There is therefore no need to materially change the implementation of the standards or the collection.
    - The nature of the NHS response to COVID-19 (e.g. significant and sudden increases in ICU capacity, separation of patient care into COVID-19 and non-COVID-19 services, and the ongoing care for the long term impact of COVID-19) 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 anonymised data from the EQC has been published on the OLP[9] 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 (e.g. additional but unused critical care beds).
- Costing and information staff may have been or be off sick, isolating or redeployed to other areas.

37. The recommendations below should be prioritised and applied as appropriate, with providers documenting that process. Factors in the prioritisation process are likely to include the availability of both internal staff and software suppliers to apply the recommendations.

38. The recommendations presented in this document are summarised as a checklist in Appendix 2.

39. Decisions made as to how costing process are amended should be recorded in the template for COVID-19 amendments now added to the Integrated Costing Assurance Log (ICAL). This does not need to be shared with NHS England and NHS Improvement when costs are submitted for the 2020/21 national cost collection, but you should retain this information for your governance process and for reference if your organisation is selected to have a Costing Assurance Process (CAP) visit.

[9] The data will be posted to the OLP. https://www.openlearning.com/nhs/courses/costing-improvement/1607594847025/eqc_data_sharing_dashboard/?cl=1

Exceptional Expenditure

40. NHS England and NHS Improvement recognises that expenditure on services has changed as a result of the COVID-19 pandemic. Where these costs relate 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.

41. There is however a type of expenditure which does not relate to a provider's own patient care. These exceptional units/services should not be included in the own patient care cost group. They should be reported as an exclusion in the national cost collection reconciliation statement regardless of how they have been reported in previous years.

42. The value of the exceptional units/services excluded should reconcile to the COVID 19 tabs in the Month 12 Audited Submission of the Provider Finance Return (PFR) 2020/21. The tabs required for the reconciliation are named[10]:

    a. 10a1. COVID_19 In Envelope, and
    b. 10a2. COVID_19 Outside Envelope
    c. 10a3. COVID_19 Nightingale
    d. 10c. Independent Sector spend (see section on 'part costs' below)

43. On the PFR tabs, both types of expenditure to support the pandemic service changes are shown. NHS England and NHS Improvement has defined the costs on these tabs as 'exceptional units/services' or own patient care costs. Exceptional units/services do **not** relate to a trust's own patients, whereas own patient care costs **do** relate to the trust's patients. The two groups have been separated on appendix 3, so the cost of the organisation's own patient care can be clear, and not be inflated by the cost of caring for other patients.

44. The Exceptional Units/Services should be reported as an authorised adjustment in the National Cost Collection reconciliation on line 34.

[10] The value for the Nightingale Units is shown in detail on the tab named 10a3. COVID_19 Nightingales, and is summarised on tab 10a1. COVID _19 In envelope.

45. The exceptional units/services costs shown in Appendix 3 and as reported on the COVID-19 tabs of the PFR include:

    i) Nightingale field hospitals & Seacole step down units

    ii) National COVID-19 laboratory testing centres, and regional/local pathology hubs providing tests for mental health and community trusts, care homes and other individuals.[11]

    iii) 111 additional capacity

    iv) Vaccination services

    v) Costs supporting other organisations' COVID-19 services, including infection prevention and control training in community, mental health, & primary care trusts

    vi) Direct provision of isolation pods, and Aging Well.

46. 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[12] of the 2020/21 Month 12 Audited Submission PFR.

    This value will need to be calculated using the categories shown on Appendix 3 and should be entered on Line 34 of the NCC reconciliation. The separate values of exceptional units/services are to be shown in the Analysis B section on the reconciliation statement, using the values from the itemised PFR Code.

47. Do not include costs where the matching income has been included in Line 2 of the reconciliation.

48. 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.

[11] In the same way as direct access, these individuals are not under the clinical responsibility of the trust beyond the test itself.
[12] See paragraph 37 above

Action 2: Briefly document the cost reconciliation process in the Integrated Costing Assurance Log (ICAL)for your own reference. This information does not need submission with the NCC for 2020/21.

Unusual additional expenditure or accounting treatments

49. There may have been changes to the GL location for the financial year 2020/21. You should review the process you usually use for the final accounts reconciliation to ensure expenditure and income are identified correctly.

50. 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'

51. 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, there may not be the full cost of care shown in the trust.

52. You may exclude these part costs from the own patient care in the national cost collection, using line 35 of the reconciliation statement, providing detail in analysis B. You should retain evidence of these costs in your ICAL for review by the costing assurance programme.

53. In many instances, Independent Sector Providers (ISP) have been centrally commissioned to provide care. These patient episodes would not have complete cost or information about the care, in the NHS provider organisation, so you should exclude these values where the whole cost is outsourced, where are only part costs for the care, or where you have costs with no activity. The total of the allowable exclusions should be reported on line 35 of the reconciliation statement.

54. There are multiple contracts and variations on this model. Table 1 illustrates the most common models. If you have a different model, or would like more information on a specific scenario, please contact us costing@improvement.nhs.uk citing "FAO FB COVID-19 guidance"

Table 1: Models of COVID-19 capacity support from ISP, with costing treatment

	Care provided by:	ISP commissioned by:	Cost	Activity treatment	Costing treatment	Exclusion line
ISP1	ISP & Trust	NHS England & NHS Improvement	Trust supplied staff to support care at an ISP	Exclude activity in trust systems (if any)	Exclude cost of staff (this is 'part cost)	Line 35 (Part of Analysis C)
ISP2	ISP	Trust	All cost born by ISP	Include activity	Include cost (trust choice to purchase ISP capacity)	No exclusion
ISP3	ISP	Trust – but trust is separately funded by NHSE&I	Trust has paid ISP, so this contractual cost is in trust GL. This value is reconcilable to the PFR.	Exclude activity in trust systems (if any)	Exclude cost (this is not core patient care income)	Line 35 (Part of Analysis C)

ISP4	Trust	NHSE&I, but trust is commissioned by ISP to provide the care	Trust provides full care	Include activity	Include cost (part of own patient care)	No exclusion
ISP5	Trust & ISP	NHSE&I Improvement, but trust is commissioned by ISP to provide the care	Trust and ISP both have expenditure on these patients – for example, Trust theatres & wards, with ISP staff	Exclude activity	Exclude cost (this is 'part cost)	Line 35 (Part of Analysis C)
ISP6	ISP	NHS England & NHS Improvement	All cost born by ISP	No activity in trust	No adjustment needed	No exclusion

55. Exclusions under ISP1 and ISP5 above will not have a value to reconcile to. You should show the values in Analysis C on the reconciliation statement.

56. Exclusions under ISP3 above will have a value to reconcile to. You should show the values in Analysis C on the reconciliation statement.

    a. ISP3a: The Month 12 audited submission of the PFR tab '10c Independent Sector spend' has the costs for supporting ISP work as reported.[13]

    b. ISP3b: From month 7-12 in North West and London Regions only, IS providers early exiting the national contract were able to be sub contracted by NHS providers. The PFR tab '10c Independent Sector spend' will have the information for the reconciliation.

    c. ISP3c: From month 10-12 the Increasing capacity framework has been brought into place. The PFR tab '10c Independent Sector spend' will have the information for the reconciliation.

57. Where you have the cost and activity of the care your own patient care cost group, but not the material running costs of equipment such as respirators[14] etc, and to report them would materially understate the cost of the care, you may exclude the costs on line 14 of the reconciliation statement. Record these areas in your ICAL so it is understood that these costs are understated.

58. You should 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 and ISP adjustments. You should ensure these items are treated appropriately in the costing system and the NCC reconciliation. This value will need to be calculated using the categories shown on Appendix 3 and should be entered on Line 35 of the

[13] More information on which lines from the PFR tab '10c Independent Sector spend' will be posted as a FAQ when the final version of the PFR for month 12 is available.
[14] Capital purchase costs are not of issue.

NCC reconciliation. The separate values of exceptional units/services are to be shown in the Analysis B section on the reconciliation statement, using the values from the itemised PFR Code.

Costing ‘own patient care’

59. The own patient care cost quantum should include:

    a. Costs of own patient care included on the COVID-19 tabs of the PFR, shown as ‘own patient care’ on Appendix 3; and

    b. COVID-19 costs not reported on the PFR.

60. NHS England and NHS Improvement appreciates that trusts may have different information available to use 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.

61. The following actions may require significant additional work and it is recommended that only those which are most important to your organisation are prioritised. As part of that prioritisation exercise you should 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, where you may decide that other costs are specific to COVID-19 patients. If COVID-19 patients cannot be identified separately from other patients, all patients should be included as suspected.[15]

    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[16].

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

[15] 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.
[16] Please note, this will not include COVID-19 costs if they have been excluded as an exceptional unit/service cost in action 1.

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. It is recognised 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 speciality may have been redeployed to support COVID-19 wards during month X but there is no information recording how many. 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[17]. The formula to calculate that change is:

1 – (actual activity/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.

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

[17] Worked examples of this can be found on the Open Learning Platform.

COVID-19 services support months and then a separate configuration at month when the redeployment happened.

63. 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.

64. It is expected that providers will wish to review other areas yet will not be able to do so due to pressures of time and resources. In such circumstances NHS England and NHS Improvement recommend that providers focus on those areas which will have the greatest impact.

65. NHS England and NHS Improvement recognises that the cost of staff in isolation or taking exceptional annual leave is significant for some trusts. For this year, these costs should be included within 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, e.g. 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

66. It is still important to maintain an assurance process, although NHS England and NHS Improvement accept this will be a ‘lighter touch’ in 2021. NHS England and NHS Improvement recommend that changes and assumptions are recorded in the Integrated Costing Assurance Log (ICAL). For this year NHS England and NHS Improvement 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 2 should be included in the signoff process, whether they were prioritised locally or not.

67. It is expected that trusts 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.

68. NHS England and NHS Improvement 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) will be moved to year 4.

Information Requirements

69. Tracking COVID-19 is important for every trust to ensure the patient record is complete.

70. The World Health Organisation has allocated two of their flexible ICD10 codes to enable effective reporting[18]:

    i) U07.1 to track patients confirmed with the COVID-19 virus, and

    ii) U07.2 for those suspected but without confirmed diagnosis.

71. These codes were already in the 2020/21 clinical coding guidance, so should be available in the patient administration system (PAS) structure (although NHS England and NHS Improvement 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.

72. There are also SNOMED-CT codes19 that can be used as an alternative in any sector:

    - 1240751000000100 | Coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 (disorder), [20]
    - 1240761000000102 | Suspected coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 (situation).

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

[18] https://www.who.int/classifications/icd/covid19/en/
[19] https://termbrowser.nhs.uk/?
[20] https://termbrowser.nhs.uk/?perspective=full&conceptId1=1240751000000100&edition=uk-edition&release=v20200415&server=https://termbrowser.nhs.uk/sct-browser-api/snomed&langRefset=999001261000000100,999000691000001104

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 providers should 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 the COVID-19 incidents cannot be tracked using ICD10 codes. Providers should 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: providers can 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).[21] This will allow you to track the cases locally. Spreadsheet IR1.2 in the technical document requires secondary diagnoses.

[21] 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
Mental Health	Your organisation should 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).[22] This will allow you to track the cases locally. Spreadsheet IR1.2 in the technical document does not require secondary diagnoses, so you should check whether your costing system can identify them to enable complete reporting.

Healthcare Resource Groups

74. The NHS Digital National Casemix Office have created a new costing grouper for 2020/21, 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 have been made to the Local Payment Grouper in the first instance and will be replicated in the 2020/21 National Costs Grouper.

75. More information and the technical output specification is available at: https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/local-payment-2020-21

Non-Admitted Patient care

76. 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.

77. All organisations should know which patients were suspected or confirmed COVID-19 patients. It may therefore be possible to track them from a locally held list. Please note we do not require this mapping as a part of the mandated

[22] 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

costing process, and recognise it is not the costing practitioner's responsibility to maintain lists of COVID-19 patients.

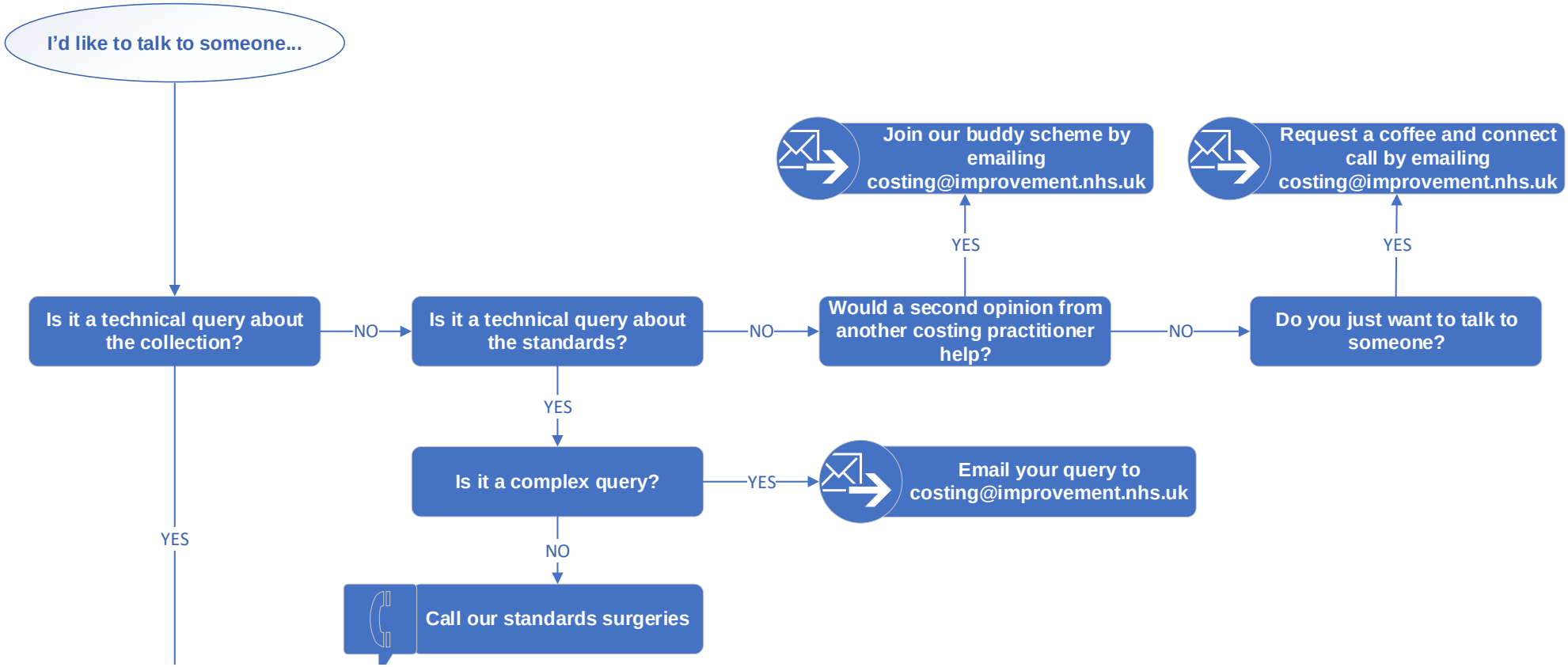
Action 12: Clinical Coding/other referencing of COVID-19 patients. NHS England and NHS Improvement recommend practitioners continue to work with clinical coders, informatics leads and software suppliers to ensure these codes are included in the patient administration system (PAS) and in the feeds to PLICS for local reporting.

Collection Requirements 2021 (FY-20/21)

78. NHS England and NHS Improvement can access the ICD10 codes for acute trusts via the National Cost Collection matching process with Hospital Episode Statistics data. NHS England and NHS Improvement are therefore not collecting the ICD10, SNOMED-CT or other identifier for COVID-19 in the 2020/21 National Cost Collection. This means there has been no change to the extract specification relating to COVID-19 coding.

79. For those organisations mandated to provide patient-level costs, refer to the PLICS extract specification for your sector for detail on the output files required.

Appendix 1 – Extract of NCCG Contact Diagram



Appendix 2 – Checklist

An editable version of this checklist is available on the online learning platform at https://www.openlearning.com/nhs/courses/costing-improvement/covid_19_guidance_202021/?cl=1.

Action	Sign off	Item	Detail	Completed [✓]
Planning		Prioritisation exercise	Work with key stakeholders to agree which of these recommended actions will be taken and in which order. Log the date of this meeting in the ICAL. Ensure software supplier availability is appropriate for the chosen prioritised areas.	
1	**	Cost for exceptional units/services, **should be** excluded from the cost quantum. The cost of 'own patient care' is included in the cost quantum. Reimbursement income is not netted off from cost.	If there are amounts in the GL (and therefore the final accounts) at year end reported in the PFR for exceptional units/services should be excluded from your cost quantum. • Nightingale field hospitals & Seacole step down units • National COVID-19 laboratory testing centres, and regional/local pathology hubs providing tests for mental health and community trusts, care homes and other individuals. • 111 additional capacity • Vaccination services • Costs supporting other organisations' COVID-19 services, including infection prevention and control training in community, mental health, & primary care trusts	

Action	Sign off	Item	Detail	Completed [✓]
			• Personal Protective Equipment (PPE) as shown on the PFR • Direct provision of isolation pods, and Aging Well. The costs should be totalled and reported on line 34 in the reconciliation as Exceptional units/services, so the value of the cost quantum is correct. You should show the breakdown of the exceptional units/services in Analysis B on the Reconciliation Statement to show your calculation. You can set up local resource codes for these costs in PLICS to identify them as cost group 'other activities' to retain the costs in your costing system for local purposes.	
2	**	Reconciliation of excluded costs	The value in the NCC reconciliation for exceptional units/services and exceptional costs should reconcile to the amount reported in the 3 PFR tabs for COVID_19 for exceptional units – see Appendix 3 for details. This should be documented in the ICAL	
3	**	Unusual treatments of costs or income in the general ledger	Understand any unusual treatments of costs or income in the general ledger including ISP adjustments, and ensure these items are treated appropriately in the costing system and the NCC reconciliation. As 2020/21 has been an exceptional year, values may not be in the same place as previous years, so you should understand both how	

Action	Sign off	Item	Detail	Completed [✓]
			the normal financial accounts have been processed and how any unusual expenditure or income has been dealt with. This section will be submitted as an exclusion on Line 35 of the reconciliation, and should reconcile to the PFR if appropriate.	
4		Allocate COVID-19 costs using a locally agreed allocation method.	Allocate any included COVID-19 specific costs to your own patients using a locally agreed method. Record allocation methods in the ICAL.	
5		Medical Staff	Adjust allocations for redeployment using available information (to ensure material costs are in the correct place). Ward rounds information is not needed.	
6		Non-medical staffing and other redeployment of resources	Check with the financial management team, the e-roster system, and ESR for any material changes, to ensure the costs in the GL still go the correct service areas.	
7	**	Clinical non-pay items	Check additional material expenditure included in your cost quantum for clinical non-pay items is allocated to the correct service area using locally available information.	

Action	Sign off	Item	Detail	Completed [✓]
8		Estates and facilities - areas that have been redeployed, and are included in the cost quantum	Amend floor area allocation tables for areas that have been redeployed	
9	**	Identify whether theatres or general wards have been turned into critical care wards	Ensure the patients are recorded on the CCMDS / with organs supported, and the cost is matched to the critical care activity.	
10	**	Identify whether theatres or other spaces have been turned into general wards?	Make sure the ward stays are flowing into PLICS on any new ward codes, and the estates information is updated in allocations. Check the cost maps to the new ward codes.	
11		Are new non-face to face (telemedicine) attendances flowing into the cost process?	All contacts done via telephone, or other virtual methods, should be recorded for patient safety and clinical information, using the data item 'consultation medium'. (See IR1.2). Check this information is flowing into PLICS.	
12		Ensure ICD10, SNOMED-CT codes or local identifiers for COVID-19 are recorded in your patient administration system (PAS)	Work with your clinical coders to understand whether the COVID-19 codes are being used. If possible, include these codes (or a separate identifier for COVID-19) in your PLICS (please note: these codes will not be required in the NCC files as they can be viewed by NHSE&I via the matched HES dataset).	

Appendix 3 – Exceptional Units & 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 has an additional column including the costing definition of either exceptional unit/service or exceptional cost. 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.

The totals on the PFR sheet are in rows 57, 89, 121, and 153. The columns are specified in the 'Column on PFR tab' in this table. For example: the reconciliation value to be excluded for Nightingale Units will be calculated as '=H57+H89+H121+H153' on PFR tab '10a3'

PFR tab	PFR Code	Allowable Cost Type Item	Costing definition	Guidance	Allocation method	Column on PFR tab
10a3	10ACOV304	Nightingale Units	Exceptional unit/service	Exclude from cost quantum	n/a	K
10a2	10ACOV69	COVID-19 virus testing - rt-PCR virus testing	Exceptional unit/service	Exclude from cost quantum	n/a	G
10a2	10ACOV3	COVID-19 virus testing - Antibody testing for social care staff	Exceptional unit/service			I
10a2	10ACOV275	COVID-19 virus testing - Rapid / point of care testing (for DHSC provided Samba2, DNA Nudge and Primer Design)	Exceptional unit/service			J
10a2	10ACOV220	NIHR SIREN testing M7 onwards	Exceptional unit/service			K
10a2	10ACOV215	COVID-19 - Vaccination programme - Vaccine centres	Exceptional unit/service			L

PFR tab	PFR Code	Allowable Cost Type Item	Costing definition	Guidance	Allocation method	Column on PFR tab
10a2	10COV225	COVID-19 - Vaccination Programme - Provider/ Hospital hubs	Exceptional unit/service	Exclude from cost quantum	n/a	TBA
10a2	10COV230	COVID-19 - Vaccination Programme - Local vaccination service	Exceptional unit/service	Exclude from cost quantum	n/a	TBA
10a2	10COV235	COVID-19 - Vaccination Programme - Lead employer	Exceptional unit/service	Exclude from cost quantum	n/a	TBA
10a2	10ACOV245	Seacole Centre Headley Court	Exceptional unit/service	Exclude from cost quantum	n/a	TBA
10a2	10ACOV240	Deployment of final year student nurses	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all admissions	TBA
10a1		Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all patient events	N
10a1		Sick pay at full pay (all staff types)	Own patient care	Include in cost quantum		O
10a1		Existing workforce additional shifts	Own patient care	Include in cost quantum		P
10a1		Backfill for higher sickness absence	Own patient care	Include in cost quantum		Q
10a1		NHS Staff Accommodation - if bought outside of national process	Own patient care	Include in cost quantum		R
10a1		PPE - locally procured	Own patient care	Include in cost quantum		S
10a1	10ACOV2	Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	Exceptional unit/service	Exclude from cost quantum	n/a	T
10a1	10ACOV68	NIHR SIREN Testing M1-M6	Exceptional unit/service	Exclude from cost quantum		U

PFR tab	PFR Code	Allowable Cost Type Item	Costing definition	Guidance	Allocation method	Column on PFR tab
10a1	10ACOV65	Lateral Flow Antigen Testing	Exceptional unit/service	Exclude from cost quantum		V
10a1	10ACOV66	LAMP testing	Exceptional unit/service	Exclude from cost quantum		W
10a1	10ACOV67	Lighthouse Laboratories and amplitude labs – Pillar 2	Exceptional unit/service	Exclude from cost quantum		X
10a1	10ACOV61	PPE - other associated costs	Own patient care	Include in cost quantum	Allocate across all patient events	Y
10a1		Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	Own patient care	Include in cost quantum	Allocate across all ITU patients	Z
10a1		Remote management of patients	Own patient care	Include in cost quantum	Allocate across all non-admitted patient care, including non-face to face contacts	AA
10a1		Support for stay at home models	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all patient events	AB
10a1		Segregation of patient pathways	Own patient care	Include in cost quantum		AC
10a1		Plans to release bed capacity	Own patient care	Include in cost quantum	Allocate across all admissions	AD
10a1		Decontamination	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all patients	AE
10a1		Additional Ambulance Capacity (ambulance sector)	Own patient care	Include in cost quantum	Allocate across all journeys	AF
10a1		Enhanced PTS	Own patient care	Include in cost quantum	Allocate across all PTS journeys	AG
10a1	10ACOV21	NHS 111 additional capacity	Exceptional unit/service	Exclude from cost quantum	n/a	AH

PFR tab	PFR Code	Allowable Cost Type Item	Costing definition	Guidance	Allocation method	Column on PFR tab
10a1	10ACOV4	After care and support costs (community, mental health, primary care)	Exceptional unit/service	Exclude from cost quantum		AI
10a1	10ACOV5	Infection prevention and control training (community, mental health, primary care)	Exceptional unit/service	Exclude from cost quantum		AJ
10a1	10ACOV54 COVID-19	Virus testing - Rapid Testing – locally procured	Own patient care	Include in cost quantum	Allocate across service areas where possible. If not possible, allocate across all patient events	TBA
10a1		Remote working for non patient activities	Own patient care	Include in cost quantum	Allocate across all patient events	AK
10a1		Internal and external communication costs	Own patient care	Include in cost quantum		AL
10a1	10ACOV17	Business Case (SDF) - Ageing Well - Urgent Response Accelerator	Exceptional unit/service	Exclude from cost quantum	n/a	AM
10a1	10ACOV12	Direct Provision of Isolation Pod	Exceptional unit/service	Exclude from cost quantum	n/a	AN
10a1		PPN and other support to suppliers	Own patient care	Include in cost quantum	Allocate across all patient events	AO
10a1		Other	Own patient care	Include in cost quantum	Allocate across all patient events	AP

Appendix 4 – Glossary of Terms

These terms are not already in the Costing Glossary, which can be found at: https://www.england.nhs.uk/approved-costing-guidance/

Term	Definition
COVID-19 patient	A patient clinical coded as either confirmed with the virus or suspected of having the virus. Once the coding no longer codes them as confirmed or suspected COVID-19, they are no longer classified as COVID-19 for costing purposes.
COVID-19 Outbreak	The period when the COVID-19 virus impacted those in the UK and the response by healthcare services. The outbreak started during March 2020, and at the time of publication the impact was still ongoing.
Exceptional service/unit	A service set up purely for the COVID-19 outbreak: eg 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 & community trusts. The patients seen by these services will not be part of the 'normal' commissioned patient services outside the COVID-19 work. The service is normally funded centrally outside of normal commissioner or provider-to-provider contracts. The cost must have been included in the NHSE&I PFR during 2020/21.
Pandemic	A pandemic is the worldwide spread of a new disease. WHO 2010 https://www.who.int/csr/disease/swineflu/frequently_asked_questions/pandemic/en/
PFR - provider finance return	The monthly finance return submitted by NHS Trusts and NHS 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 extreme situation caused by the COVID-19 outbreak has required a more flexible approach. In this context, for the 2020/21 financial year, we are allowing trusts to make decisions on where they need to reduce compliance to the standards to enable a reasonable cost output to be created. All such decisions should be documented in the ICAL, so appropriate governance can be maintained.

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