Report by Acting Chief Executive – Monthly Update: March 2020

Authors: Rebecca Brown and Stephen Ward Sponsor: Rebecca Brown **Trust Board paper D**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	N/A	
Executive Board	N/A	
Trust Board Committee	N/A	
Trust Board	N/A	

Executive Summary

Context

The Acting Chief Executive's monthly update report to the Trust Board for March 2020 is attached.

Questions

Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the Board's input regarding the content of this month's report to the Board.

For Reference** (edit as appropriate)**:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures [Yes]

Safely and timely discharge	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Yes]
e-Hospital	[Yes]
More embedded research	[Yes]
Better corporate services	[Yes]
Quality strategy development	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required – None Required.

- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A

- If an EIA was not carried out, what was the rationale for this decision? On the basis that this is a monthly update report.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	**X**	ALL
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	**X**	N/A
New Risk identified in paper: What ***type*** and ***description***?	N/A	N/A
None		

5. Scheduled date for the **next paper** on this topic: April 2020 Trust Board
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **26 MARCH 2020**

REPORT BY: **ACTING CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – MARCH 2020**

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1. Introduction

1.1 My report to this Board meeting is confined to two important issues:

(a) the Trust's response to COVID-19;

(b) the Reconfiguration Programme – public consultation

2 UHL response to COVID-19

2.1 I have attached, for information, a copy of a letter dated 17th March 2020 sent to all NHS bodies by the NHS Chief Executive and Chief Operating Officer which sets out the framework for the Trust's response to COVID-19.

2.2 As Board members will appreciate, the situation is fast-moving and I will therefore make a presentation at the Board meeting on the latest position and the Trust's response and plans.

3. Reconfiguration Programme

3.1 We are delighted that after many years of planning and discussions our proposals to invest £450m in modernising and upgrading our hospitals were supported by Government, with an announcement of funding in principle made during October last year.

3.2 We want to create a modern, fit-for-purpose environment that helps us continue delivering the high quality of care provided by our dedicated staff, as well as the cutting edge technologies and treatments that are already being used to transform and save lives.

3.3 Our ambition is simple: we want to build hospitals and services that local people can be proud of, both now and for generations to come.

3.4 Since Government support for funding was secured we have been working hard to finalise the details of our ambitious proposals and, with our partners, have been progressing through regional and national assurance processes. We had hoped that, subject to completion of these, we would be in a position to publish the full details of

what is planned (often called the pre-consultation business case or PCBC) and launch a formal public consultation during April.

3.5 Those assurance processes are still ongoing. Meanwhile the current Coronavirus outbreak means that the priority for the NHS must, rightly, be on doing everything we can to support patients and care for those most in need during what will be a particularly challenging time.

3.6 These two things mean that the consultation will now start later than originally expected.

3.7 The fluidity of the national situation means that we cannot, at this stage, provide details of exact timescales. However, we hope that consultation may be able to commence during the early part of the Summer - though this will have to be kept under review. We also remain committed to publishing our detailed plans in advance of consultation and will provide an update on timescales for this in due course. We will also continue conversations with our local Joint Health Overview and Scrutiny Committee on progress over the coming months.

4. Conclusion

4.1 The Trust Board is invited to consider and comment upon this report and the attached appendices.

Rebecca Brown
Acting Chief Executive

23rd March 2020

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services

Copy to:
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums
Chairs of ICSs and STPs
NHS Regional Directors
NHS 111 providers

NHS England and NHS Improvement
80 London Road
Skipton House
London SE1 6LH
england.spoc@nhs.net

17 March 2020

Dear Colleague,

IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19

Thank you for your extensive work to date to prepare for this rapidly increasing pandemic, following the NHS declaration of a Level 4 National Incident on 30 January.

Last night the Government announced additional measures to seek to reduce the spread across the country. It is essential these measures succeed. However as the outbreak intensifies over the coming days and weeks, the evidence from other countries and the advice from SAGE and the Chief Medical Officer is that at the peak of the outbreak the NHS will still come under intense pressure.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to redirect staff and resources, building on multiple actions already in train. These will:

- Free-up the maximum possible inpatient and critical care capacity.
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
- Support staff, and maximise their availability.

- Play our part in the wider population measures newly announced by Government.
- Stress-test operational readiness.
- Remove routine burdens, so as to facilitate the above.

Please therefore now enact the following measures:

1. Free-up the maximum possible inpatient and critical care capacity

The operational aim is to expand critical care capacity to the maximum; free up 30,000 (or more) of the English NHS's 100,000 general and acute beds from the actions identified in a) and b) below; and supplement them with all available additional capacity as per c) below. To that end, trusts are asked now to:

a) Assume that you will need to postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months. However you also have full local discretion to wind down elective activity over the next 30 days as you see best, so as to free up staff for refresher training, beds for COVID patients, and theatres/recovery facilities for adaptation work. Emergency admissions, cancer treatment and other clinically urgent care should continue unaffected. In the interim, providers should continue to use all available capacity for elective operations including the independent sector, before COVID constraints curtail such work. This could free up 12,000-15,000 hospital beds across England.

b) Urgently discharge all hospital inpatients who are medically fit to leave. Community health providers must take immediate full responsibility for urgent discharge of all eligible patients identified by acute providers on a discharge list. For those needing social care, emergency legislation before Parliament this week will ensure that eligibility assessments do not delay discharge. New government funding for these discharge packages and to support the supply and resilience of out-of-hospital care more broadly is being made available. (See section 6f of this letter). Trusts and CCGs will need to work with local authority partners to ensure that additional capacity is appropriately commissioned. This could potentially free up to 15,000 acute beds currently occupied by patients awaiting discharge or with lengths of stay over 21 days.

c) Nationally we are now in the process of block-buying capacity in independent hospitals. This should be completed within a fortnight. Their staff and facilities will then be flexibly available to you for urgent surgery, as well as for repurposing their beds, operating theatres and recovery facilities to provide respiratory support for COVID-19 patients. As soon as we have the detailed capacity map of what will be available in each part of the country we will share that with you via Regional Directors. NHS trusts and foundation trusts should

free up their own private pay beds where they exist. In addition, community health providers and social care providers are asked to free up community hospital and intermediate care beds that could be used flexibly within the next fortnight. These measures together could free up to 10,000 beds.

2. Prepare for, and respond to, large numbers of inpatients requiring respiratory support

Emerging international and UK data on COVID-19 patients suggests that a significant proportion who are hospitalised require respiratory support, particularly mechanical ventilation and to a lesser extent non-invasive ventilation.

a) Work is well in hand nationally to secure a step change in oxygen supply and distribution to hospitals. Locally, hospital estates teams have now reported on their internal oxygen piping, pumping and bedside availability. All trusts able to enhance these capabilities across their estate are asked to do so immediately, and you will be fully reimbursed accordingly. The goal is to have as many beds, critical care bays, theatre and recovery areas able to administer oxygen as possible.

b) National procurement for assisted respiratory support capacity, particularly mechanical ventilation, is also well under way in conjunction with the Department of Health and Social Care. In addition, the Government is working with the manufacturing sector to bring new manufacturers online. These devices will be made available to the NHS across England, Wales, Scotland and Northern Ireland according to need. Mark Brandreth, chief executive of Agnes Jones and Robert Hunt foundation trust is now supporting this work.

c) In respect of PPE, the DHSC procurement team reports that nationally there is currently adequate national supply in line with PHE recommended usage, and the pandemic influenza stockpile has now been released to us. However locally distribution issues are being reported. Michael Wilson, chief executive of SASH, is now helping resolve this on behalf of the NHS. In addition if you experience problems there is now a dedicated line for you: 0800 915 9964 / 0191 283 6543 / Email: supplydisruptionservice@nhsbsa.nhs.uk.

d) A far wider range of staff than usual will be involved in directly supporting patients with respiratory needs. Refresher training for all clinical and patient-facing staff must therefore be provided within the next fortnight. A cross-specialty clinical group supported by the Royal Colleges is producing guidance to ensure learning from experience here and abroad is rapidly shared across the UK. This will include: a short education package for the entire NHS workforce; a service guide, including for anaesthetics and critical care; COVID-19 clinical management guides in collaboration with NICE.

e) Segregate all patients with respiratory problems (including presumed COVID-19 patients). Segregation should initially be between those with respiratory illness and other cases. Then once test results are known, positive cases should be cohort-nursed in bays or wards.

f) Mental Health, Learning Disability and Autism providers must plan for COVID-19 patients at all inpatient settings. You need to identify areas where COVID-19 patients requiring urgent admission could be most effectively isolated and cared for (for example single rooms, ensuite, or mental health wards on acute sites). Case by case reviews will be required where any patient is unable to follow advice on containment and isolation. Staff should undergo refresher training on physical health care, vital signs and the deteriorating patient, so they are clear about triggers for transfer to acute inpatient care if indicated.

3. Support our staff, and maximise staff availability

a) The NHS will support staff to stay well and at work. Please ensure you have enhanced health and wellbeing support for our frontline staff at what is going to be a very difficult time.

b) As extra coronavirus testing capability comes on line we are also asking Public Health England as a matter of urgency to establish NHS targeted staff testing for symptomatic staff who would otherwise need to self-isolate for 7 days. For those staff affected by PHE's 14 day household isolation policy, staff should - on an entirely voluntary basis - be offered the alternative option of staying in NHS-reimbursed hotel accommodation while they continue to work. Sarah-Jane Marsh, chief executive of Birmingham Women's and Children's foundation trust is now supporting this work.

c) For staff members at increased risk according to PHE's guidance (including pregnant women), if necessary, NHS organisations should make adjustments to enable staff to stay well and at work wherever possible. Adjustments may include working remotely or moving to a lower risk area. Further guidance will be made available and the Royal College of Obstetrics and Gynaecology will provide further guidance about pregnant women.

d) For otherwise healthy staff who are at higher risk of severe illness from COVID-19 required by PHE's guidance to work from home, please consider how they can support the provision of telephone-based or digital / video-based consultations and advice for outpatients, 111, and primary care. For non-clinical staff, please consider how they can continue to contribute remotely. Further guidance will be made available

e) The GMC, NMC and other professional regulators are also writing to clinicians who have relinquished their licence to practice within the past three years to see whether they would be willing to return to help in some capacity.

f) Urgent work is also underway led by chief nursing officer Ruth May, NHS chief people officer Prerana Issar and Health Education England, the relevant regulators and universities to deploy medical and nursing students, and clinical academics. They are finalising this scheme in the next week.

g) All appropriate registered Nurses, Midwives and AHP's currently in non-patient facing roles will be asked to support direct clinical practice in the NHS in the next few weeks, following appropriate local induction and support. Clinically qualified staff at NHSE/I are now being redeployed to frontline clinical practice.

h) The four UK chief medical officers, the national medical director, the Academy of Medical Royal Colleges and the GMC have written to all UK doctors stressing that it will be appropriate and necessary for clinicians to work beyond their usual disciplinary boundaries and specialisms under these difficult circumstances, and they will support individuals who do so. (see https://www.aomrc.org.uk/wp-content/uploads/2020/03/0320_letter_supporting_doctors_in_COVID-19.pdf) Equivalent considerations apply for nurses, AHPs and other registered health professionals.

4. Support the wider population measures newly announced by Government

Measures announced last night are detailed at:
https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults

a) Ministry of Housing, Communities and Local Government (MHCLG) and local authorities in conjunction with their Local Resilience Forums (LRFs) have lead responsibility for overseeing support for older and vulnerable people who are going to be 'shielded' at home over the coming months. Community health services and voluntary organisations should engage with LRFs on how best to do this.

b) A number of these individuals would be expected to have routine or urgent GP, diagnostic or outpatient appointments over the coming months. Providers should roll out remote consultations using video, telephone, email and text message services for this group as a priority and extend to cover all important routine activity as soon as possible, amongst others. David Probert, chief

executive of Moorfields foundation trust, is now leading a taskforce to support acute providers rapidly stand up these capabilities, with NHSX leading on primary care. Face-to-face appointments should only take place when absolutely necessary.

c) For patients in the highest risk groups, the NHS will be identifying and contacting them over the coming week. They are likely to need enhanced support from their general practices, with whom they are by definition already in regular contact. GP services should agree locally which sites should manage essential face-to-face assessments. Further advice on this is being developed jointly with PHE and will be available this week.

d) As part of the overall 'social distancing' strategy to protect staff and patients, the public should be asked to greatly limit visitors to patients, and to consider other ways of keeping in touch such as phone calls.

5. Stress-test your operational readiness

a) All providers should check their business continuity plans and review the latest guidance and standard operating procedures (SOP), which can be found at https://www.england.nhs.uk/coronavirus/.

b) Trust Incident Management Teams – which must now be in place in all organisations - should receive and cascade guidance and information, including CAS Alerts. It is critical that we have accurate response to data requests and daily sitrep data to track the spread of the virus and our collective response, so please ensure you have sufficient administrative capacity allocated to support these tasks.

c) For urgent patient safety communications, primary care providers will be contacted through the Central Alerting System (CAS). Please register to receive CAS alerts directly from the MHRA: https://www.cas.mhra.gov.uk/Register.aspx.

d) This week we are undertaking a system-wide stress-testing exercise which you are asked to participate in. It takes the form of a series of short sessions spread over four days from today. Each day will represent a consecutive week in the response to the outbreak, starting at 'week six' into the modelled epidemic. We would strongly encourage all Hospital Incident Management Teams with wider system engagement (including with primary care and local government representation) to take part.

6. Remove routine burdens

To free you up to devote maximum operational effort to COVID readiness and response, we are now taking the following steps nationally:

a) Cancelling all routine CQC inspections, effective immediately.

b) Working with Government to ensure that the emergency legislation being introduced in Parliament this week provides us with wide staffing and regulatory flexibility as it pertains to the health and social care sector.

c) Reviewing and where appropriate temporarily suspending certain requirements on GP practices and community pharmacists. Income will be protected if other routine contracted work has to be substituted. We will issue guidance on this, which will also cover other parts of the NHS.

d) Deferring publication of the NHS People Plan and the Clinical Review of Standards recommendations to later this year. Deferring publication of the NHS Long Term Plan Implementation Framework to the Autumn, and recommending you do the same for your local plans.

e) Moving to block contract payments 'on account' for all NHS trusts and foundation trusts for an initial period of 1 April to 31 July 2020, with suspension of the usual PBR national tariff payment architecture and associated administrative/ transactional processes.

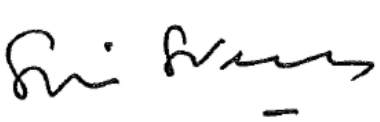
f) Additional funding to cover your extra costs of responding to the coronavirus emergency. Specific financial guidance on how to estimate, report against, and be reimbursed for these costs is being issued this week. The Chancellor of the Exchequer committed in Parliament last week that *"Whatever extra resources our NHS needs to cope with coronavirus – it will get."* So financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.

COVID-19 presents the NHS with arguably the greatest challenge it has faced since its creation. Our health service - through our skilled and dedicated staff - is renowned for the professional, flexible and resilient way that it responds to adversity. Please accept our sincere thanks for your leadership, and that of your staff, in what is going to be a highly challenging period.

This is a time when the entire NHS will benefit from pulling together in a nationally coordinated effort. But this is going to be a fast-moving situation requiring agile

responses. If there are things you spot that you think we all should be doing differently, please let us know personally. And within the national framework, do also use your discretion to do the right thing in your particular circumstances. You will have our backing in doing so.

With best wishes,



Sir Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX: CORONAVIRUS COST REIMBURSEMENT

This guidance sets out the amended financial arrangements for the NHS for the period between 1 April and 31 July. These changes will enable the NHS and partner organisations (including Local Authorities and the Independent Sector) to respond to COVID-19. We will continue to revise this guidance to reflect operational changes and feedback from the service as the response develops.

We will shortly be making a payment on account to all acute and ambulance providers to cover the costs of COVID-19-related work done so far this year, with final costs for the current financial year being confirmed as part of the year end processes. This initial payment will be based on information already submitted by providers. Future payments will be based on further cost submissions.

All NHS providers and commissioners must carefully record the costs incurred in responding to the outbreak and will be required to report actual costs incurred on a monthly basis. Accurate record keeping during this time is crucial - record keeping must meet the requirements of external audit, and public and Parliamentary scrutiny.

To support reimbursement and track expenditure we will in due course be asking all relevant organisations to provide best estimates of expected costs from now until the expected end of the peak outbreak. We will provide further guidance with relevant assumptions in order to support you in making these estimates.

REVENUE COSTS

Contractual payments and provider reimbursement

We are suspending the operational planning process for 2020/21.

We will provide all NHS providers a guaranteed minimum level of income reflecting the current cost base on the following basis:

a) Commissioners should agree block contracts with the NHS providers with whom they have a contract (NHS Trusts, Foundation Trusts, Mental Health, Community and Ambulance trusts) to cover the period 1 April to 31 July. This should provide a guaranteed monthly payment. For CCGs the value of this payment will be calculated nationally for each CCG/provider relationship. This figure will be based on the average monthly expenditure implied by the provider figures in the M9 Agreement of Balances return plus an uplift that allows for the impact of inflation (including pay uplifts and CNST) but excluding the tariff efficiency factor. It will not include activity growth. For mental health trusts the uplift will include an additional sum consistent with

delivering the Mental Health Investment Standard. The monthly payment should include CQUIN and assume 100% delivery.

b) Trusts should suspend invoicing for non-contracted activity for the period 1 April to 31 July. A sum equivalent to the historical monthly average will be added to the block contract of the provider's coordinating commissioner. Providers should continue to record all activity including NCAs in SUS in the normal way.

c) A national top-up payment will be provided to providers to reflect the difference between the actual costs and income guaranteed by steps 1 and 2 where the expected cost base (which will be calculated as the average monthly expenditure over the period November to January uplifted for inflation) is higher. The Financial Recovery Fund and associated rules will be suspended during this period. The top-up payment will take into account individual provider CNST contributions compared to that funded in the allowance for cost inflation.

We will provide these numbers to Commissioners and Providers on Monday 23 March.

Providers should claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. These reasonable costs should include:

a) Evidenced increases in staffing costs compared to the baseline period associated with dealing with increased total activity.

b) Increases in temporary staffing to cover increased levels of sickness absence or to deal with other caring responsibilities (e.g. to look after other family members).

c) Payments for bank or sub-contractor staff to ensure all sickness absence is covered consistent with Government's announced policy and public health advice which aren't otherwise covered under normal practice; and

d) Additional costs of dealing with COVID-19 activity. For example: the costs of running NHS111 assessment pods; increases in the volumes required or prices of equipment to deal with the response to the virus which aren't offset by reductions elsewhere; extra costs of decontamination and transport for the ambulance service; higher testing volumes in acute-based laboratories; and community-based swabbing services.

Claims should be made on a monthly basis, alongside regular monthly financial reports. This should provide sufficient funds for providers to deliver a break-even

position through the period and will provide the basis against which we will monitor financial performance.

We will monitor the impact of any changes in income levels from non-NHS services, in particular from local authorities. Providers should escalate to regional teams as appropriate.

The payments made by commissioners under block contract arrangements should not be revised to reflect any short falls in normal contractual performance during this period. The majority of NHS acute providers are already exempt from the majority of contract sanctions; for the duration of the outbreak until further notice any remaining contract sanctions for all NHS provider groups are to be suspended.

It is important that providers and commissioners pay promptly during this time, so that cash flow for NHS and non-NHS suppliers of goods and services does not become a barrier to service provision.

The arrangements described above should mean there is minimal requirement for interim working capital support during this period. Providers that believe they require supplementary working capital support should follow the normal procedure to access such support.

Funding for commissioners

Commissioner allocations for 2020/21 have already been notified as part of operational planning and will not be changed. However, in assessing individual commissioner financial positions and affordability we will take into account:

a) The impact of the block contracting approach set out above including both the cost of removing the tariff efficiency factor and the benefit of excluding activity growth from the calculation.

b) Expected reductions in investments for service developments
    - the temporary arrangements for non-contracted activity, transferring funding to make sure that lead commissioners have adequate funds to pay providers; and
    - the costs of additional service commitments as described below for example for out of hours provision, additional NHS111 investment, purchase of step-down beds and provision of rapid discharge/ additional social care capacity.

c) We will also be reviewing planned transformation initiatives, and where we consider that these will not be able to proceed during the coronavirus emergency we will reflect this in the distribution of transformation funding.

d) In addition, a number of NHS commissioners are dependent on additional central support to fully cover their expenditure. NHSE/I will calculate a central top up payment on broadly the same basis as FRF to cover the difference between allocations as set out above and expected costs.

Financial Governance

The maintenance of financial control and stewardship of public funds will remain critical during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance. Any financial mismanagement during this period will be dealt with in exactly the same way as at any other time.

We recommend that NHS organisations undertake an urgent review of financial governance to ensure decisions to commit resources in response to COVID-19 are robust. Naturally, all organisations should test the resilience of their finance functions and business continuity plans to make sure that the most important elements (running payroll, paying suppliers, core reporting) can continue even with significant staff absences. We are also asking you to consider the resilience of your fraud prevention arrangements.
As normal financial arrangements have been suspended, no new revenue business investments should be entered into unless related to Covid-19 or unless approved by NHSE/I as consistent with a previously agreed plan. Where costs have already been committed or contractual commitments entered into, providers should agree an approach with NHSE/I as above.

Normal consultancy approval and agency reporting requirements must be maintained during this period.

SPECIFIC ADDITIONAL FUNDING CONSIDERATIONS

Purchase of enhanced discharge support services

CCGs will be asked to work with their local authority partners to commission additional out-of-hospital care and support capacity, in particular to facilitate step down of patients from secondary care and so free up acute beds. These are expected to be a blend of care home beds, hospices, and home-care support.

Detailed operational guidance for the procurement and management of these beds will be issued separately including more detailed finance guidance. To make sure that funding decisions do not restrict the pace of discharges, additional resources will be provided to pay for the community bed or a package of care post-discharge for any

patient that needs it. New guidance will also ensure that eligibility assessments do not delay new care packages being put in place. We will continue to review this approach and will ask CCGs and local authorities to move to standard commissioning and funding routes once the impact of Covid-19 sufficiently diminishes – you should plan therefore on the basis of an average length of care package.

Additional funding will be provided based on monthly cost returns from CCGs.

Specialised services

As described above, Specialised Services contracts will follow the same principles as CCG commissioned activity, and block values will be based on the average 2019/20 expenditure up to month 9, with an uplift to recognise the impact of pay uplifts and other cost increases.
Arrangements for pass through Drugs and Devices costs will continue to operate as currently on a cost and volume basis, to ensure that providers do not face any financial consequences of any increases in activity or cost.

Specialised providers will be required to respond to the most serious cases of COVID-19 through the provision of High Consequence Infectious Disease units, Extracorporeal Membrane Oxygenation services and other specialised care functions. Any specific investments and costs incurred by these units are being coordinated through the National Highly Specialised team.

NHS 111

NHS 111 has been commissioned nationally to provide a dedicated Covid-19 response service. This service will continue to be contracted for and funded nationally. In addition, having reviewed the pressures on the wider NHS 111 service additional funding will be released from NHSE/I via lead commissioners, who will then make necessary arrangements for payment to NHS 111 providers.

General Practice

The key principle is that from 1 April we free up practices to prioritise workload according to what is necessary to prepare for and manage the outbreak, and therefore guarantee that income will be protected if other routine contracted work has to be substituted. This does not prevent us from continuing to measure activities (for example those undertaken with QOF) but it ceases to put 2020/21 income at risk for performance.

We will make sure that funding does not influence clinical decision making by ensuring that all GP practices in 2020/21 continue to be paid at rates that assume they would

have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of QoF, DES and LES payments.

CCGs should plan to make payments on this basis. NHSE/I will reimburse any additional costs as part of our wider finance agreement on Covid-19.

Out of Hours Provision

CCGs have been asked to procure additional GP out of hours provision in order to provide home-based care for any patients that have tested positive for coronavirus in the community. CCGs will be reimbursed for the additional costs incurred in delivering this service through the allocations process. CCGs will be required to submit a monthly return of additional cost incurred which will provide the basis of additional payments. To keep the administrative burden to a minimum, where a CCG has contracted for this service on behalf of itself and others, reimbursement will be directed through the lead CCG.

Community Pharmacy

Where required, CCGs will be reimbursed for the following:

a) An NHS Urgent Medicines Supply Service for patients whose General Practice is closed.

b) A Medicines Delivery Service to support Covid-19 positive and vulnerable patients self-isolating at home.

c) Payments to contractors who are required to close due to Covid-19 related reasons.

Optometry and dental

For the time being we expect that funding for dentistry and optometry will continue in line with existing contractual arrangements using assumptions rolled over from 2019/20 where required. We will keep this under review and address any issues as they arise.

Third and Independent Sector Providers

Details of reimbursement for any additional services to be procured from the third sector or from independent sector organisations will be issued in due course.

CAPITAL COSTS

NHSE/I will shortly issue indicative capital allocations for 2020/21. Additional capital expenditure will be required to support our response to the virus in a number of areas, including purchase of pods, capital modifications to existing estate, purchasing of ventilators and other medical equipment, and IT assets to enable smarter working including remote consultations. In a number of cases NHSE/I may bulk-purchase assets to secure the necessary resource as quickly as possible. However, this will not always be practical or desirable, so below are the arrangements for providers and commissioners to access capital in relation to the COVID-19 response. The key criteria against which we will assess claims are:

a) The proposed expenditure must be clearly linked to delivery of our COVID-19 response;
   NHS
b) In the case of asset purchases, the asset must be capable of being delivered within the expected duration of the outbreak; and

c) In the case of modifications to estate, the works must be capable of being completed within the expected duration of the outbreak.

Commissioner capital

We anticipate that individual claims for capital expenditure by commissioners will fall within the delegated budgetary limits for NHSE/I of £10m. Any requests for capital expenditure by commissioners including any assets being purchased on behalf of general practice should be relayed to NHSE/I regional teams for assessment with the national team, following which the required capital allocation will be issued.

Provider capital

We anticipate that individual claims for capital expenditure by providers will fall within the delegated budgetary limits for trusts of £15m. Any requests for capital expenditure by providers should be relayed to NHSE/I regional team for rapid assessment with the national team to enable swift decision making and disbursement of cash where appropriate. PDC charges will not be levied on any funding supplied in connection with COVID-19.

Summary

Group	Service line	Funding method
Revenue costs		
All NHS organisations	Contracting basis	All providers to move to block contract,
	Self-isolation of workers	To be directly reimbursed as required
	Increased staff costs in the event of sick or carer's leave	To be directly reimbursed as required
	Other additional operating costs	Reasonable costs to be reimbursed
Acute providers	Pod provision	Initial on-account payment based on submissions received so far Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
	Laboratory costs	To be directly reimbursed as required
CCGs	Purchase of step-down beds	Final 19/20 payment based on cost submissions Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
	Out of Hours (primary care) capacity increase	Additional allocations to be paid to CCGs to pass on to providers
Specialised services	Patient admissions	To be funded through block contractual payments
	Drugs costs	Payments for drugs not included in tariff will continue in the normal way
Ambulance providers	Additional PPE and cleaning	Initial on-account payment based on submissions received so far Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
Community	Swabbing services	Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions

Group	Service line	Funding method
NHS 111	National CRS function	Costs to be reimbursed nationally
	Additional local 111 funding	Additional allocations to be paid via CCGs where agreed
Capital costs		
Acute providers	Equipment and estate modification as required	PDC allocation from DHSC to provider trust
CCGs (including primary care)	Equipment as required	NHS England allocation to CCGs funded via DHSC mandate adjustment