

A reckoning: the continuing cost of COVID-19

Overview

The COVID-19 pandemic has increased the cost of running frontline NHS services by £4-5bn a year. These costs are in addition to other key financial factors, such as the need to fund capital investment and recover care backlogs, and they will be with us for the duration of the three-year period that is expected to be covered by the upcoming Comprehensive Spending Review (CSR). This joint briefing by NHS Providers and the NHS Confederation, based on survey data from 54% of the provider sector, explains the long-term impact of the pandemic on the NHS's day-to-day running costs, and calls on the government to ensure these costs are met in full.

Context

The NHS has been under significant financial pressure for some time. Between 2010 and 2019, the health service experienced the longest and deepest financial squeeze in its history.¹ The five-year funding settlement announced in June 2018, while welcome, was only enough to enable the NHS to keep pace with increasing demand – it was never sufficient to fully recover performance levels or deliver truly transformative change.² The settlement also excluded vital areas such as health education, public health, social care and capital spending. Areas that, to this day, are all in significant need of additional investment and also impact on the NHS's running costs.

Then the NHS faced COVID-19, the seismic impact of which is unlike anything the service has experienced in its 73-year history. Some of the additional costs created by the COVID-19 virus are obvious – for example, the funding needed to set up effective test, trace and isolate systems, deliver the ongoing vaccination programme and address the record care backlog. Other costs are less visible, but this does not mean they are less significant.

One area that is at risk of being overlooked is the unavoidable impact of COVID-19 on the NHS's underlying cost base. COVID-19 has made the delivery of frontline services more expensive. There are many reasons for this, such as extra cleaning to meet strict infection prevention and control (IPC) requirements, service expansion to cope with higher patient demand in terms of volume and acuity, and the need to bring in bank or agency workers to cover for staff who are self-isolating after a positive COVID-19 test or close contact.

1. Health Foundation (2019), *Health and social care funding: Priorities for the new government* <https://www.health.org.uk/publications/long-reads/health-and-social-care-funding>

2. Charlesworth, A (2018), *Running to stand still: Why £20.5bn is a lot but not enough to do everything*. Health Foundation. <https://www.health.org.uk/blogs/running-to-stand-still-%E2%80%93-why-%C2%A3205bn-is-a-lot-but-not-enough-to-do-everything>

In 2020/21 the costs of treating COVID-19 patients, combined with the knock-on frontline costs described above, totalled £7.8bn.³ These additional costs will have reduced since the most intense phases of the pandemic. But they have not gone away and will be with us for the foreseeable future. Although vaccines are currently breaking the link between infections, hospital admissions and deaths from the virus, living with COVID-19 long term and dealing with even low levels of hospital admissions means that, for some years to come, frontline services will continue to be more expensive to provide than they were before the pandemic. In the Prime Minister's words, as a nation and as an NHS, we need to "learn to live with COVID".

To better understand how COVID-19 has changed the NHS's underlying cost base, NHS Providers and the NHS Confederation conducted a rapid survey of chief executives and finance directors across acute, mental health, community and ambulance services. The survey aimed to capture the drivers of extra cost, the scale of any cost increase, how long the extra cost will be incurred, and the overall impact on the NHS's budget.

The survey was open from 18-25 August 2021 and sent out via email. 116 trusts responded to the survey, representing 54% of the provider sector. All trust types and regions were represented.

The survey deliberately focused on the impact of COVID-19 on the NHS's core running costs. It did not cover the following other items of NHS cost, all of which will need to be addressed in the forthcoming Spending Review:

- **Capital:** An adequate capital settlement to fund the government's manifesto commitment to invest in essential NHS infrastructure and the 40 new hospitals.
- **Recovery:** Recovering the backlogs of care that have built up as a result of COVID-19. The amount required will depend on the level of 'lost' referrals over the COVID-19 period that come forward, and the speed of backlog recovery. Current estimates suggest an extra investment requirement of £3.5-4.5bn over each of the next three financial years.⁴
- **Efficiencies:** Recognition that the NHS was unable to deliver its usual 1.1 per cent rate of efficiency savings during 2020/21 and 2021/22, adding an additional £1.5bn to its baseline costs. Furthermore, the operational pressures the NHS is facing now and is likely to face, plus the need to maintain infection control measures, may limit trusts' ability to deliver efficiencies. The government must therefore be realistic about the rate of productivity gains that can be delivered in the years ahead.

3. NHS England and NHS Improvement (2021), NHS England and NHS Improvement Board meetings held in common: Month 12 financial position update 2020/2. <https://www.england.nhs.uk/wp-content/uploads/2021/06/240621-board-meeting-item-4i-month-12-financial-position-update-20-21.pdf>

4. This £3.5-4.5bn estimate comes from a combination of private discussions with NHS England; private estimates from both NHS Providers and NHS Confederation following conversations with members; and previous estimates, for example The Institute for Fiscal Studies (see: <https://ifs.org.uk/publications/15432>). We are assuming that around 50% of 'lost referrals' will require treatment and that care backlogs should be eliminated within a notional three-year period.

- **Workforce and public health:** Investment in staff training and development and public health – the elements of NHS activity that are covered by the Department of Health and Social Care departmental budget, as opposed to the frontline NHS budget that is allocated to NHS England.
- **Costs covered by central government:** The central government-funded costs of COVID-19, such as test and trace and ongoing COVID-19 vaccination.
- **Social care:** Investment to reform and stabilise social care.

NHS Providers and the NHS Confederation represent the frontline NHS. Our estimate, based on the above, is that the NHS England 2022/23 budget needs to increase by around £10 billion compared to the 2018 NHS settlement to cover ongoing COVID-19 costs (£4.6 billion); recover care backlogs (£3.5-4.5bn); and make appropriate allowance for lost efficiency savings.

It is vital that the government provides this resource in its CSR this autumn. If it fails to do so, it will inevitably become harder for patients to access the care they need, when they need it and for the NHS to provide the right quality of timely care to all who require it.

Findings

The drivers behind the expanding cost base

This section details the 15 factors related to COVID-19 that are driving the estimated £4.6 billion increase in NHS running costs for 2022/23. We asked trusts to indicate the significance of each factor, and how long it is likely to remain a recurrent cost pressure. We have included anonymised examples to illustrate the impact these drivers have on frontline trusts, and have set them out in order of significance as reported by respondents to our survey.

As would be expected from a survey of this type, there is, inevitably, some overlap between the categories and within the individual trust examples quoted. It is important to note that this does not affect the estimate of the total extra costs trusts face as the survey only asked for an overall figure representing trusts' 2022/23 cost base – this was deliberately not broken down by individual driver.

It is also important to note that the pattern of extra costs – the size of impact, the balance of different drivers and the length of impact – will differ by trust. For example, an acute or mental health trust with an old, single site inflexibly configured hospital is likely to incur higher proportionate extra cost than a trust with modern, multi-site hospitals that can be more easily reconfigured to cope with COVID-19. We are confident that surveying the entire sector, with a 54% response rate and representation across each trust type, will address these disparities.

1. Infection prevention and control (IPC)

- **Explanation:** COVID-19 necessitates IPC measures to minimise transmission of the COVID-19 virus in healthcare settings. Trusts face increased cleaning costs, and many have had to redesign or redevelop estates that were not designed to facilitate a pandemic response.
- **Significance:** 90% of trusts said that IPC is a very significant or significant driver of additional cost, with many trusts providing a wide range of examples illustrating the significantly increased cost they face.
- **Longevity:** Trusts viewed this as a long-term recurrent cost, with 54% saying the cost would be needed until 2024/25 and beyond. This aligns with the consensus epidemiological expert view that the virus is likely to continue circulating for a significant period of time and that trusts will therefore have to continue to treat COVID-19 positive, or suspected COVID-19, patients.⁵

Trust examples:

“The trust is currently spending around £400k per month over and above the contract value largely arising from IPC requirements for cleaning but also site security and waste disposal. If this continued it would represent a circa 35-40% increase on the baseline annual contract value. Until such time as IPC requirements revert to pre-COVID standards, these costs will be almost impossible to remove.” Finance Director, combined acute and community trust, London

⁵ See, for example, <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Covid-19-futures.pdf>

"Largest single area of cost increase is staffing for reconfigured wards to support infection control and cohorting. Cost impact is high due to being a smaller hospital built in the early 1970s and having had no significant upgrade since, therefore limited side rooms and space allowance for each bed. Multiplying up of staff costs to separate care of hot, cold and amber patient cohorts appropriately." Finance Director, acute trust, South West

"Cannot see us stepping this down as we are unlikely to accept we will revert to 'dirtier' hospitals in the future now the importance of extra cleaning has been proven." Finance Director, combined acute and community trust, South West

2. Staff absence and backfill

- **Explanation:** COVID-19 decreases productivity by significantly increasing the amount of time off staff must take due to sickness, isolation requirements and caring responsibilities. Trusts must then fill these gaps with expensive and hard-to-source bank or agency staff, with significant pressure on bank and agency pay rates.
- **Significance:** 90% of trusts said staff absence and backfill is a very significant or significant driver.
- **Longevity:** 45% of trusts believed this would last until the end of 2022/23.

Trust examples:

"This includes the impact to workforce, including higher absence rates, backfill, agency costs, premium shift payments etc." Finance Director, acute trust, North West

"For 999 services, additional capacity to cover staff absences. Extra cleaning costs for stations and vehicles. For patient transport services, additional capacity as more patients need to travel alone." Deputy Director of Finance, ambulance trust

3. Service expansion and 'cohorting' to cope with higher demand and acuity

- **Explanation:** Some services have expanded to cope with increased demand. This can bring extra costs – for example, moving services off site, remote monitoring of patients at home, more ambulance activity, seeking to meet sharp increases in demand for mental health services and services for children, and providing vaccines. In addition, COVID-19 patients are 'cohorted' together, which costs more per patient than if they were treated in general wards.
- **Significance:** 89% of trusts said service expansion is a very significant or significant driver.
- **Longevity:** 50% of trusts said this driver would persist until the end of 2024/25 and beyond.

Trust examples:

"1) Expansion of seven-day working to improve flow and manage infection risk within ED. This has resulted in a significant increase in the medical input to acute / urgent care.

2) Introduction of Enhanced Post Operative Care areas as an alternative to ITU to enable throughput of elective surgical cases whilst ITU capacity is occupied by COVID patients and other emergencies with associated nursing, medical and equipping costs." Finance Director, acute trust, Midlands

"As a mental health trust, we have seen a huge increase in inpatient demand across Q1 and 2 21/22. Decision to Admit (DTA) from EDs is up 20%+ on the same period in 2019/20 and this is manifesting in significant increased private bed usage. Whilst we don't yet know the balance between backlog demand and new / higher acuity demand as a result of the pandemic the impact appears significant." Finance Director, mental health and learning disability trust, London

"Pressures on urgent care pathway due to hot and cold flow due to infection control measures. Additional footprint requires staffing. Infection control unable to see these pathways being removed in the future as have highlighted the need for separation for infection prevention (whether it is covid, flu, norovirus). This then includes the knock-on costs of services displaced and having to be re-provided." Finance Director, combined acute and community trust, South West

4. Miscellaneous workforce-related costs

- **Explanation:** Other examples of additional workforce costs include increasing overtime costs, higher staff ratios owing to higher patient acuity, and funded nursing care for COVID-19 patients.
- **Significance:** 81% of trusts said that other workforce-related costs are a very significant or significant driver.
- **Longevity:** 37% of trusts said this driver would last until the end of 2024/25 and beyond.

Trust example:

"Front door temperature checkers are costing circa £100k per month." Finance Director, acute trust, South East

5. Non-backlog-related output gaps

- **Explanation:** In addition to coping with care backlogs, trusts must continue to meet their Long Term Plan goals. This includes making significant investments to deliver improvements in a wide range of areas including tackling out-of-area placements, improving diagnostic capacity and reducing cancer waiting times.
- **Significance:** 73% of trusts said that non-backlog-related output gaps is a very significant or significant driver.

- **Longevity:** 29% of trusts said this driver would last until the end of 2024/25 and beyond and another 28% said until the end of 2023/24.

Trust example:

"Increases in out-of-area bed activity, increases in workforce that has resulted in increases in agency usage, extra capacity that is not in the rollover block contract, loss of services that used to provide a contribution to overheads." Finance Director, mental health and learning disability trust, South West

6. Reduction in income

- **Explanation:** In normal times, many trusts receive additional revenue from a range of sources such as commercial partnerships, private patients, research and development, education, and local authority contracts. Many of these income streams have been disrupted by the COVID-19 pandemic.
- **Significance:** 66% trusts said that reduction in income is a very significant or significant driver.
- **Longevity:** The reduction in income is thought to be spread over the next few years with 41% of trusts expecting the cost to last until 2022/23 and 17% saying 2023/24.

Trust example:

"Impact on private patient services – impact on income rather than costs – we repurposed our private patient ward in March 2020 to a Covid Assessment Unit (CAU) as it has a separate entrance and separate rooms for each bed. This enabled us to separate blue and green patients. This has severely limited the amount of private patient activity we can deliver and resulted in a significant loss of income (£2m). At the moment these beds are still required currently to serve as a CAU but also to support hospital flow. This income loss is not reflected in the additional costs of the pandemic." Deputy Director of Finance, combined acute and community, South West

7. Extra capital and depreciation charges

- **Explanation:** Capital investment often has revenue consequences, such as increased depreciation charges. Capital investment to support the response to COVID-19 has therefore brought additional revenue pressure for most trusts.
- **Significance:** 63% of trusts said that capital and depreciation charges are a very significant or significant driver.
- **Longevity:** 69% of trusts said this driver would last until the end of 2024/25 and beyond.

Trust example:

"Capital charges plus additional staffing costs and the building of new wards with better IPC potential than can be found in a 1960's tower block." Chief Executive, acute trust, North East

“-c£5m impact from the difference between cost inflation and funding in allocations. Clear inability to deliver efficiencies over a two-year period. Funding into systems is mainly non recurrent, and most of it needs to become recurrent.

“-c£4m hit from the loan to PDC [public dividend capital] conversion and additional depreciation / PDC costs as a result of additional national capital monies over the past two years where national capital funding has been supplied but no revenue funding. The national infrastructure programmes need to recognise both capital and revenue funding need.”

Finance Director, acute trust, North West

8. IT costs

- **Explanation:** Many staff are working from home and some services are now delivered remotely. This has increased IT costs for trusts, and has required many legacy IT systems to be upgraded to support remote or hybrid working practices.
- **Significance:** 63% of trusts said that IT costs are a very significant or significant driver.
- **Longevity:** 55% of trusts said this driver would last until the end of 2024/25 and beyond.

Trust example:

“Remote monitoring of patients has required additional costs of licences to support devices to be used by patients at home. The costs of reviewing the data from the devices is similar to the previous cost of the outpatient model so no efficiency saving. The device cost has increased our baseline costs but is seen to support better outcomes and patient experience as well as reducing demand for hospital facilities.” Finance Director, acute specialist trust, North West

“This includes the impact to having extra kit, so depreciation charges or larger rooms for accommodate extra space, IT equipment, lower income from car parking.” Finance Director, acute trust, North West

9. Demand from COVID-19 patients

- **Explanation:** COVID-19 increases demand on critical care, and treating patients with the disease requires providing a new set of clinical therapies, with associated costs.
- **Significance:** 62% of trusts said that demand from COVID-19 patients is a very significant or significant driver for increasing the cost base.
- **Longevity:** A fifth of trusts said they did not know how long the demand from COVID-19 patients would last. A third of trusts said until the end of 2022/23, and nearly a fifth said until the end of 2024/25 or beyond, suggesting a significant proportion of trusts believe COVID-19 pressures will persist for the long term.

Trust examples:

“Covid patients requiring specific beds/wards and critical care capacity; additional cleaning between MRI, CT, etc scans meaning lower throughput and additional costs for rent of university/independent sector capacity; inefficiency of sperate steams for covid and non-covid

patients; hospital retail outlets renegotiating or terminating leases.” Finance Director, combined acute and community trust, North East

“We have had to open an additional acute mental health ward to due to challenges of managing COVID positive patients who are agile and in a disturbed state. Cost impact understated in that we cannot afford to put in additional capacity to return to 19/20 activity levels and hence are seeing our waiting times grow, certainly for our community and learning disabilities services (with mental health having received additional SR monies). Significant impact on the productivity of our community services as more domiciliary visits which take longer, patients being discharged earlier from hospital increasing demand and people presenting later and therefore more poorly.” - Finance Director, combined mental health / learning disability and community trust, Midlands

10. Supporting staff wellbeing

- **Explanation:** More than 18 months since the pandemic began too many NHS frontline staff are burned-out and exhausted. This creates risks to their health and wellbeing, and to trusts’ ability to retain staff. Mitigating this means making investments in additional resources such as wellbeing hubs and counselling.
- **Significance:** 62% of trusts said that supporting staff wellbeing are a very significant or significant driver.
- **Longevity:** 41% of trusts said this driver would last until the end of 2024/25 and beyond.

Trust example:

“The costs associated with the additional health and wellbeing measures we have put in i.e. Employee Assistance Programme.” Finance Director, combined mental health/learning disability and community trust, North West

11. Admin costs of managing a larger waiting list

- **Explanation:** A rising waiting list brings increased administration costs, such as hiring both temporary and permanent staff to manage referrals. This must be met over and above agreed full-time equivalent budgets for the year.
- **Significance:** 53% said that the admin costs of managing a larger waiting list is a very significant or significant driver.
- **Longevity:** 24% of trusts said this driver would last until the end of 2022/23, with a further quarter saying until the end of 2023/24, and another quarter saying until the end of 2024/25 and beyond.

Trust examples include employing additional staff to handle incoming patient and GP queries but also proactively calling people on the waiting list to verify they still require treatment. Cost of proactive communications to enable those on the waiting list to ‘wait well’ for example, patient letters informing patients of their likely wait times, if they are going to be longer than the 18-week standard.

12. Personal protective equipment (PPE)

- **Explanation:** New IPC measures have led to increased spending on PPE. This includes gloves, aprons, and high protection FFP3 (or equivalent) face masks.
- **Significance:** Over half (52%) of trusts said that PPE is a very significant or significant driver.
- **Longevity:** 37% of trusts said until the end of 2024/25 and beyond.

Trust example:

"Procurement/supply chain– additional warehouse space for the storage of PPE, ICU consumables and surplus non-ICU related stock offsite (£244k), staffing resilience in supply chain, staffing costs associated with the stock management of additional PPE delivery model (to one site for redistribution to all sites) (£517k)." Finance Director, acute trust, London

13. Long COVID

- **Explanation:** Long COVID means trusts must spend more money on long-term care management, including setting up new clinics, with associated administration and staff costs.
- **Significance:** 34% of trusts said the impact of long COVID is very significant or significant, with a further 37% saying it was neither significant nor insignificant.
- **Longevity:** 38% of trusts said long COVID would be more persistent and last until the end of 2024/25 and beyond. A further 28% said they did not know how long this driver would impact their cost base.

Trust example:

"Increase nursing on respiratory wards so that more patients can be on nasal high flow and reduced reliance on additional critical care beds, this has increased nursing costs but more cost effective and better for patient than critical care provision." Chief Executive, acute trust, South West

14. Tackling inequalities

- **Explanation:** Fighting COVID-19 and dealing with its wider impacts equitably means tackling health inequalities. This means ensuring communities that have been more adversely affected by the pandemic are not disadvantaged during the recovery, for example via longer waiting times or worse outcomes.
- **Significance:** 30% of trusts said tackling inequalities are a very significant or significant driver.
- **Longevity:** 43% of trusts said this driver would last until the end of 2024/25 or beyond.

Trust examples include special provision of 'novel' vaccination approaches such as pop-up clinics and mobile buses to ensure appropriate take up in areas with lower take up. Costs of conducting detailed waiting list analysis and matching to demographic data (for example postcode analysis) to identify those from areas of likely inequality.

15. Testing excluding costs reimbursed by test and trace

- **Explanation:** Trusts consistently test staff and patients to ensure their wards remain free of COVID-19. Testing takes place throughout acute settings, for example within emergency departments, before admission and during a patient's stay in hospital.
- **Significance:** 28% of trusts said that testing is a very significant or significant driver.
- **Longevity:** 23% of trusts said they did not know how long this driver would last. Another 23% said until the end of 2022/23.

Trust example:

"Significant additional costs in relation to COVID prevalence, management and treatment, predominantly segregation of pathways, additional workforce and rapid testing. In addition to the increasing costs base, there is also a continuing loss of non-NHS income." Finance Director, acute trust, South East

Two trust-level case study examples

Another way of analysing the extra costs is to look at the picture from the perspective of a single trust, as opposed to the 15 different drivers, which will affect each individual trust differently. Set out below are two trust-level case studies.

Mental health and community trust in the Midlands

A combined mental health and community trust estimates its running costs have increased by £2.9m because of the pandemic. The most significant driver is staffing costs for mental health and community inpatient wards, which have risen by £1.3m on 2019/20 levels, due to increased absence rates, plus the need to create and staff additional wards for COVID-19-positive patients. COVID-19-related absence among community services staff, plus additional visits for patients not able to access usual services, is costing £200,000 per year. Additional cleaning and IPC measures currently cost an extra £400,000 a year, while managing and delivering PPE stock provided by Department of Health and Social Care costs £100,000.

Switching to remote working has also brought additional costs. The trust has bought new laptops to enable clinical and corporate services to operate remotely: revenue costs associated with this capital investment – for example depreciation costs – are calculated at £500,000 for at least the next five years. In addition, VPN and mobile phone costs to support home working are currently running at £350,000 a year.

Acute trust in London

Under a 'best case' scenario, an acute trust in London projects that its ongoing COVID-19 costs will total £5m, while it will also lose £6.4m due to reduced income, creating an additional financial pressure of £11.4m a year. The largest single element relates to its intensive therapy unit: retaining the ability to flex up ITU capacity at short notice in response to further COVID-19 waves costs the trust £1.8m per year. Health and wellbeing support for staff, including mental health first aiders, musculoskeletal support and counselling, are projected to cost £670,000 a year. Testing patients alone, assuming staff testing will not continue, will cost £460,000, while costs associated with staff sickness and isolation will drop from over £1m per year now to £260,000 long term.

Income from non-NHS patient care has fallen: the trust used to generate £19m a year by treating private patients, plus a further £3.6m from overseas visitors. This is projected to fall to £15.6m for private patients and £550,000 for overseas visitors in the long term.

Estimate for the increased cost base

In the survey, trusts provided us with three data points to calculate how much they estimate their cost base for the next 12 months will grow due to these drivers. The survey captured the trust's 2019/20 turnover, an estimate of extra recurrent annual costs, and the percentage these costs represented compared to 2019/20 baseline. A full explanation of the methodology can be found in the data annex.

The data showed that:

- the estimated extra recurrent annual costs for the sector, when factoring in variation across trust type, is £4.6bn
- trusts estimated that the extra recurrent costs they would incur over the next 12 months, as a proportion of their 2019/20 turnover, ranged from 0% to 15% – the average for the sector was a recurrent cost increase of 4.56%
- there is some variation by trust type, highlighted in Table 1.

Table 1
Aggregate estimate of extra recurrent annual costs by trust type

Trust type	Average percentage of these extra costs compared to 2019/20 turnover baseline	Sum of respondents by trust type (n =99)	National aggregate calculation (n =213)
Acute specialist trust	4.77%	£50,791,000	£126,977,500
Acute trust	4.95%	£1,138,059,700	£2,113,539,443
Ambulance trust	6.94%	£180,065,000	£225,081,250
Combined acute and community trust	3.74%	£351,991,000	£860,422,444
Combined mental health / learning disability and community trust	2.73%	£84,487,000	£222,738,455
Community trust	5.15%	£320,838,000	£802,095,000
Mental health / learning disability trust	3.84%	£90,700,000	£249,425,000
Grand total	4.56%	£2,216,931,700	£4,600,279,092

Conclusion

COVID-19 has increased the NHS's day-to-day running costs for the long term. Factors such as new IPC measures, increased staff absence rates, expanding services to deal with increased demand, and providing much more PPE for staff, will be with us for the duration of the three-year period likely to be covered by this autumn's CSR.

Data collected from trusts suggests providers' costs will increase by an estimated £4.6bn on 2019/20 levels, due to factors directly attributable to the COVID-19 pandemic. It should not be assumed that meeting these cost increases alone will be enough to adequately equip the NHS for the challenge it faces in the years ahead.

In addition to recognising and covering these costs, it is also essential that the government commits to: providing a capital settlement sufficient to fund its manifesto commitments to invest in NHS infrastructure, staff training and development, and reforming social care; funding additional activity to recover backlogs of care; factoring in the efficiency savings that could not be delivered due to COVID-19 and its knock-on effects; and covering the centrally funded costs of COVID-19, such as test and trace.

For the NHS to meet the ongoing cost of living with COVID-19, and to make progress on recovering from the pandemic, these cost pressures must be taken as a whole and funded in full.

Data annex

Methodology

NHS Providers and the NHS Confederation conducted a survey of all chief executives and finance directors of all trusts in England. 116 trusts responded, and all trust types and regions were represented.

Table 2
Survey sample

Trust type	Responses	Total number of trusts	% of trust type represented
Acute specialist trust	8	15	53%
Acute trust	50	78	64%
Ambulance trust	8	10	80%
Combined acute and community trust	21	44	48%
Combined mental health / learning disability and community trust	12	29	41%
Community trust	7	15	47%
Mental health / learning disability trust	10	22	45%
Grand total	116	213	54%

Findings

Table 3
Significance of drivers

1. Ongoing demand for Covid patients, excluding long Covid (e.g. critical care capacity and Covid therapies)						
Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
16%	46%	22%	10%	0%	5%	1%
2. Managing long Covid						
Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
2%	33%	37%	17%	0%	3%	8%
3. PPE						
Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
8%	44%	33%	10%	2%	3%	0%
4. Infection prevention and control arrangements, including extra cleaning costs						
Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
32%	58%	8%	3%	0%	0%	0%

5. Service expansion and/or cohorting to cope with higher patient demand and acuity (e.g. ED expansion, reconfigured bed base to mitigate bed losses, moving services off site to allow for expansion, remote monitoring and virtual wards, additional ambulance fleet, vaccination activity, NHS 111 etc)

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
50%	39%	8%	2%	0%	1%	1%

6. Costs to deal with non-backlog-related output gaps (outsourced diagnostics, out-of-area placements, waiting list initiatives etc to continue to deliver 2019/20 levels of activity, working with voluntary sector)

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
31%	42%	16%	4%	3%	3%	1%

7. Direct costs of managing a larger waiting list, e.g. more admin and patient query/contact support

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
10%	42%	34%	9%	3%	2%	0%

8. Enhanced measures to tackle health inequalities as a result of COVID-19 (e.g. more outreaching of acute care, working with voluntary sector)

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
6%	24%	40%	17%	1%	4%	8%

9. Staff absence and backfill (COVID-19-positive staff and self-isolation due to close contacts and increased rates to secure additional temporary bank/agency staff)

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
44%	45%	10%	0%	1%	0%	0%

10. Enhanced staff wellbeing support

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
13%	50%	30%	6%	1%	0%	0%

11. Other workforce-related costs (e.g. increase in staff costs for overtime, continuing health care, funded nursing care, increased staffing ratios due to higher acuity patients)

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
36%	45%	16%	2%	1%	0%	0%

12. Testing (excluding costs reimbursed or directly incurred by test and trace)

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
3%	25%	49%	12%	2%	9%	0%

13. IT costs (e.g. legacy costs for enhanced IT systems, continued home working)

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
17%	46%	34%	3%	1%	0%	0%

14. Extra capital and depreciation charges as a result of extra capital investment since COVID-19 began

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
23%	40%	28%	3%	3%	2%	2%

15. Reduction in income (e.g. non-NHS, R&D, education, commercial income and local authority funding)

Very significant	Significant	Neither significant nor insignificant	Insignificant	Very insignificant	No increase in cost base	Don't know
18%	48%	24%	6%	2%	1%	1%

**Table 4
Longevity of drivers**

1. Ongoing demand for Covid patients, excluding long Covid (e.g. critical care capacity and Covid therapies)

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
12%	34%	10%	17%	7%	20%

2. Managing long Covid

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
2%	10%	10%	38%	12%	28%

3. PPE

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
7%	27%	8%	37%	7%	15%

4. Infection prevention and control arrangements, including extra cleaning costs

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
4%	22%	10%	54%	1%	9%

5. Service expansion and/or cohorting to cope with higher patient demand and acuity (e.g. ED expansion, reconfigured bed base to mitigate bed losses, moving services off site to allow for expansion, remote monitoring and virtual wards, additional ambulance fleet, vaccination activity, NHS 111 etc)

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
5%	17%	18%	50%	2%	9%

6. Costs to deal with non-backlog-related output gaps (outsourced diagnostics, out of area placements, waiting list initiatives etc. to continue to deliver 2019/20 levels of activity, working with voluntary sector)

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
4%	26%	28%	29%	6%	7%

7. Direct costs of managing a larger waiting list, e.g. more admin and patient query/contact support

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
5%	24%	26%	25%	15%	5%

8. Enhanced measures to tackle health inequalities as a result of COVID-19 (e.g. more outreaching of acute care, working with voluntary sector)

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
2%	15%	11%	43%	11%	19%

9. Staff absence and backfill (COVID-19-positive staff and self-isolation due to close contacts and increased rates to secure additional temporary bank/agency staff)

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
21%	45%	16%	9%	1%	9%

10. Enhanced staff wellbeing support

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
2%	29%	20%	41%	2%	6%

11. Other workforce-related costs (e.g. increase in staff costs for overtime, continuing health care, funded nursing care, increased staffing ratios due to higher acuity patients)

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
6%	29%	19%	37%	2%	7%

12. Testing (excluding costs reimbursed or directly incurred by test and trace)

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
6%	23%	13%	15%	19%	23%

13. IT costs (e.g. legacy costs for enhanced IT systems, continued home working)

Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
3%	19%	9%	55%	7%	7%

14. Extra capital and depreciation charges as a result of extra capital investment since covid-19 began					
Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
2%	7%	10%	69%	8%	5%

15. Reduction in income (e.g. non-NHS, R&D, education, commercial income and local authority funding)					
Until the end of 2021/22	Until the end of 2022/23	Until the end of 2023/24	Until the end of 2024/25 or beyond	No increase in cost base	Don't know
16%	41%	17%	10%	5%	10%

Table 5
Estimate of extra recurrent annual costs by trust type

Trust type	Sum of estimate of extra recurrent annual costs	Average of estimate of extra recurrent annual costs	Count of trust in sample
Acute specialist trust	£50,791,000	£8,465,166.67	6
Acute trust	£1,138,059,700	£27,096,659.52	42
Ambulance trust	£180,065,000	£22,508,125.00	8
Combined acute and community trust	£351,991,000	£19,555,055.56	18
Combined mental health / learning disability and community trust	£84,487,000	£7,680,636.36	11
Community trust	£320,838,000	£53,473,000.00	6
Mental health / learning disability trust	£90,700,000	£11,337,500.00	8
Grand total	£2,216,931,700	£22,393,249.49	99

Table 6
Aggregate estimate of extra recurrent annual costs by trust type

Trust type	Total number of trusts in England	Sum of trust type	Aggregate calculation
Acute specialist trust	15	£50,791,000	£126,977,500
Acute trust	78	£1,138,059,700	£2,113,539,443
Ambulance trust	10	£180,065,000	£225,081,250
Combined acute and community trust	44	£351,991,000	£860,422,444
Combined mental health / learning disability and community trust	29	£84,487,000	£222,738,455
Community trust	15	£320,838,000	£802,095,000
Mental health / learning disability trust	22	£90,700,000	£249,425,000
Grand total	213	£2,216,931,700	£4,600,279,092



The NHS Confederation

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We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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NHS Providers

is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

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