

Performance Tracker 2023

Public services as the UK approaches
a general election



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About Performance Tracker

Performance Tracker is an ongoing analysis of the performance of public services. This eighth edition brings together more than 250 indicators to analyse how the pandemic has affected spending, staff and performance in nine public services.

Produced in partnership by the Institute for Government and the Chartered Institute of Public Finance and Accountancy (CIPFA), the analysis examines the comparative, and in many cases interconnected, problems faced by public services – and whether they have sufficient funding or staff to return performance to pre-pandemic levels by 2025, and at the end of the next likely spending review, in 2027/28.

Find out more:

<https://www.instituteforgovernment.org.uk/performance-tracker>

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Forewords

I am delighted to introduce the 2023 edition of *Performance Tracker*. This year's report could not be more timely. Public services have shot up the agenda in recent months – NHS waiting lists are at record levels, the government has been forced to close some school buildings due to safety concerns about the concrete used in their construction, and to free up space in overcrowded prisons it is planning the early release of prisoners.

These issues are acute, but they are the result of short-term decisions made by policy makers over years and decades. They have also been compounded by successive crises: Covid, political instability, inflation and, most recently, industrial action. The result has been services crumbling under unprecedented pressure.

Whoever wins the next election will have difficult decisions to make. Current spending plans – to which both the Conservatives and Labour have committed – are incredibly tight, and imply spending cuts for some services already performing far worse than on the eve of the pandemic. To stick to those plans is a legitimate decision for either party to make, but they must be honest with the public about the likely consequences.

In this year's *Performance Tracker* we analyse the spending, performance, staffing and demand for nine public services. In the cross-service analysis, we draw out the common issues that contribute to poor performance and identify the questions that any government serious about improving this will need to address.

This work is only possible thanks to the contributions of dozens of people working in public services who kindly give up their time to speak to us. These people have added richness and depth to our data analysis, and we hope that readers will appreciate their insights as much as we have done.



Dr Hannah White OBE, Director, Institute for Government

Since the last edition of *Performance Tracker* we've seen significant political and economic turmoil. Unprecedented levels of inflation, the cost of living and energy crises, repeated industrial action and, of course, the war in Ukraine have all taken a terrible toll on our public sector, as they have individuals, too. As the cost of living crisis rages on, and with winter just around the corner, we are far from seeing light at the end of the tunnel.

This eighth edition of *Performance Tracker* provides a snapshot of public services during this time of immense challenge. A period that was earmarked for recovery after the onslaught of the pandemic was instead consumed by geopolitical uncertainty.

Together with the Institute for Government, we demonstrate that the aftershocks of the pandemic are still being felt throughout the public sector. In fact, eight of the nine services covered are performing worse now than they were in 2019/20, with the situation particularly dire in prisons, hospitals, general practice and adult social care. The kind of recovery the sector hoped for, and desperately needed, has simply not materialised.

The sector has also been ravaged by workforce issues, leaving our services weakened by the loss of experienced staff and high turnover. As the worst of the pandemic passed, we saw increasing numbers of public service staff moving roles or leaving services entirely. The result was a record number of vacancies in the NHS, adult social care, children's social care, and the highest prison officer leaving rate on record.

Over the last year, strikes have been widespread across services, causing detrimental delays, backlogs and disruption. Crucially, we uncover significant weaknesses in the government's response to the strike action, perhaps most notably the government's refusal to negotiate pay for months, which only extended the strikes.

I hope that the fever around the forthcoming general election does not detract from the work that needs to begin right now to improve and revitalise our public services. Whoever takes the keys to Number 10 needs to be prepared to make some difficult decisions, with a focus on a shift to longer-term planning instead of the short-termism that has characterised much of recent policy making. I hope this edition of *Performance Tracker* is a reminder of just how damaging the last few years have been to the sector, and that it can act as a roadmap to building better and more resilient services for all.



Rob Whiteman, Chief Executive, CIPFA

Summary

Automatic
fire door
Keep clear



Public services that have for years been creaking are now crumbling. The public is experiencing first-hand the consequences of successive governments' short-term policy making – perhaps most starkly in the forced closure of more than 100 schools just days before the start of the new academic year in September 2023, for fear they may collapse. In the NHS, the elective waiting list reaches a new record high every time figures are published, industrial action by doctors is now into its eighth month and patients find it increasingly difficult to get an appointment with an ever-shrinking number of GPs.

Seven local authorities have issued a section 114 notice – effectively signalling 'bankruptcy' – in the last three years, compared to just one in the first three decades that the measure existed. Other councils have warned they may follow suit. In criminal courts, more than a quarter of the most serious cases take more than a year to be resolved. And prisons are at bursting point, with inmates routinely being held in police cells to deal with overcrowding and the justice minister even considering 'renting' cells in other countries.

All this is the result not just of the pandemic, clearly disruptive though that was, but also of decisions taken over the course of many years and different administrations. Public sector pay freezes and below-inflation pay rises in the 2010s fuelled dissatisfaction with pay that this year, amid high inflation, erupted into the worst public sector strikes for decades. Governments have underinvested in capital across all public services for more than half a century, leaving GP surgeries, hospitals, schools, courts and prisons that are not fit for purpose.

Cuts to local government funding at the start of the 2010s have forced local authorities to make their own cuts in response – usually falling on unprotected responsibilities like neighbourhood services. Even statutory services such as adult social care have become more closely rationed. Fragility has become a defining characteristic of today's public services.

Whoever wins the next general election will face tough choices when it comes to public services. The current spending plans beyond the end of this spending review period, which runs to 31 March 2025, leave even the most well-funded services – general practice and hospitals – with little breathing room. The prospects for other services are bleak. If the next government sticks to current commitments, performance in some services, particularly the criminal justice system, will almost certainly deteriorate even further.

This report analyses the current state of nine public services – general practice, hospitals, adult social care, children's social care, neighbourhood services, schools, police, criminal courts and prisons – and the comparative, and often interconnected, problems they face. It sets out the consequences of spending choices that this and the next government may take.

Performance in most services is still worse than before the pandemic – and much worse than in 2010

All the services covered in this report, with the sole exception of schools, were performing worse on the eve of the pandemic than a decade earlier. The situation was particularly dire in prisons, hospitals, general practice and adult social care. But they are performing even worse now. The situation is most severe in criminal courts and hospitals.

The crown court backlog is at a record high, reaching 64,709 cases in June 2023, compared to just 40,826 in March 2020. However, accounting for the greater complexity of cases in the backlog, which now includes a disproportionate number of jury trials, the 'true backlog' is now equivalent to 89,937 cases.

Hospitals are doing substantially worse on all major performance metrics. The elective waiting list continues to grow, reaching 7.8m in August 2023, up from 4.6m on the eve of the pandemic. And in 2022/23, little over half of those attending A&E were admitted, transferred or discharged within four hours (56.7%), compared to more than three quarters in 2019/20 (75.4%). This also compares unfavourably to a longstanding target of 95%, and even to a new target, announced in December 2022, of 76%.

Performance is worse in some services despite substantial spending and staffing increases. In hospitals there were approximately 13% more doctors and nurses in March 2023 as compared to March 2020, yet many areas of activity have not returned to pre-pandemic levels. Adult social care has also seen substantial spending increases in recent years, but these have largely been eaten up by higher costs to provide the same level of service, meaning that there has been little progress in reducing unmet and under-met need.

Public service performance has been weakened by underinvestment in capital

The pandemic is no longer having a meaningful direct impact on the performance of public services. But their ability to bounce back from the shock of Covid has been severely hampered by historic underinvestment in capital – that is, buildings, equipment and the like.

The UK has long invested less in its public services than other wealthy nations. Taking health as an example, since 1970 there have only been two years in which the UK did not spend below (often much below) the OECD average; today the NHS has half as many CT scanners per head of population as the OECD average. But even by these low standards, the decade before the pandemic saw particularly deep cuts to the capital spending of the departments overseeing the services covered in this report. The worst hit was the Ministry of Justice, where annual capital spending averaged less than half the real-terms spending in 2007/08.

Decades of underinvestment in capital has had a serious impact on the productivity of public services. Teachers, nurses, doctors and social workers find it much harder to do their jobs in crumbling and cramped buildings, when using old computers running out-of-date software or lacking the latest equipment. At times they cannot do their jobs at

all: St Mary's Hospital, one of four major trauma hospitals in London, reports that it is often unable to use its outpatient department because it is frequently flooded with sewage.¹ Across hospitals, schools, criminal courts, prisons and the road network the maintenance backlog now totals £37bn.

Workforce problems are further damaging performance

The effectiveness of public services has been further weakened by the loss of experienced staff and high turnover. As the worst of the pandemic receded, there was an uptick in public service staff moving roles or leaving services entirely. The result was a record number of vacancies in the NHS, adult social care and children's social care, and the highest prison officer leaving rate on record. Some of those trends have reverted to pre-pandemic levels, but other problems persist.

Experienced – and therefore often more productive – staff have left many services, to be replaced by inexperienced recruits. The proportion of prison officers with more than 10 years' experience has never been lower. The proportion of registered nurses with less than five years' experience rose from 19.3% in March 2019 to 25.5% in March 2023.

Other services are facing a full-blown workforce crisis. In children's social care, workforce numbers are falling for the first time, resulting in a record vacancy rate. Huge problems exist in teacher training: around 30% fewer trainees started postgraduate teacher training in 2022–23 than the government thinks were needed, based on trends in pupil numbers and other factors.

In many cases – particularly adult social care, nursing, hospital doctors and GPs – the government is increasingly relying on international recruitment to fill vacancies. This gives the government less control over the future of the workforce, as it is unable to influence the number of staff trained overseas and is directly competing with other countries.

The government has struck deals with nurses, ambulance drivers, barristers and teachers during the recent months of industrial action, in a bid to assuage an increasingly dissatisfied workforce, but junior doctors and consultants remain on their picket lines. The strikes have, however, led to considerable service disruption: less than half of pupils attended school during the various teachers' strikes, the backlog in crown courts rose by more than 8%, and the NHS rescheduled more than one million hospital appointments as a result. These are problems that these services can ill-afford as they struggle to address backlogs and performance issues exacerbated by the pandemic. The government's approach to strikes – particularly its refusal to negotiate on pay for months – likely extended their duration and thus the level of disruption caused to public services.

Current spending plans will likely mean further declines in service performance

When it was first announced, the 2021 spending review looked generous, with spending rising more quickly over the course of its three years than any other spending review since 2004. But unexpectedly high inflation has eroded the real-terms value of that settlement. While additional funding has been provided to some services, the tightness of these spending plans means that most will not be able to return to pre-pandemic performance levels by the end of this spending review period in March 2025.

The situation after the end of the current spending review is worse still. The government's spending plans from April 2025 onwards – which Labour has also committed to – are incredibly tight, with just 1% annual real-terms increases pencilled in. But taking account of government commitments on foreign aid and defence, and funding that would be required to deliver the NHS long-term workforce plan, the settlements for *unprotected* areas of public spending will be much less, averaging -1.2% per year in real terms. If these spending plans were implemented, then it is likely that all services covered in this report, other than children's social care, would be performing worse in 2027/28 than on the eve of the pandemic.

Lord Gus O'Donnell, the former cabinet secretary, has described these spending plans as "totally unsustainable"² and whoever forms the next government will likely face huge public and political pressure to provide public services with more generous settlements.

Public service performance improvement is possible but requires a big change in government's approach

Fixing the problems described in this report will take time and will not be easy. After a decade of sustained funding pressure, there is no meaningful fat to trim without damaging public service performance further. But higher standards could be achieved with existing funding and staffing levels – if services are reformed to work more productively. Such improvements will, however, require a different approach from government.

This report does not set out to produce an exhaustive list of solutions – that will involve political choices – but instead sets four commitments that any government serious about addressing the decline in public services must make:

- **A new multi-year budget for each public service** that is sufficient to enable politically sustainable performance levels without emergency top-ups.
- **A long-term capital programme**, which addresses the UK's historic and comparative lack of investment in public sector buildings, equipment and IT.
- **A stable long-term policy agenda** with clear political and official leadership, which addresses the unsustainable levels of churn among ministers, officials and policy makers.
- **An improved approach to workforce management**, including on setting pay, workforce planning and enhancing working conditions, to reset the relationship with public service staff and resolve recruitment and retention problems.

In the absence of serious action to improve public service productivity, the government risks getting stuck in a 'doom loop', with the perpetual state of crisis burning out staff and preventing services from taking the best long-term decisions. Escaping this will not be easy and whoever forms the next government will be hindered by the short-sighted decisions of its predecessors.

Hard decisions are necessary but, with a sustained change in approach, serious improvement to public service performance is possible. It will always have been better to start fixing these problems years ago – but the next best time is now.

Table **Service performance ratings, October 2023**

Service	Performance on the eve of pandemic vs 2009/10	Performance now vs on the eve of pandemic	Funding adequate to...	
			Return to pre-pandemic performance levels by the end of 2024/25	Maintain performance levels between the end of 2024/25 and 2027/28
General practice	↓ Much worse	↘ Worse	No	Yes
Hospitals	↓ Much worse	↓ Much worse	Maybe	Yes
Adult social care	↓ Much worse	↘ Worse	No	Maybe
Children's social care	↘ Worse	→ About the same	Yes	Maybe
Neighbourhood services	↘ Worse	↘ Worse	No	Maybe
Schools	↗ Better	↘ Worse	No	Maybe
Police	↘ Worse	↘ Worse	Yes	No
Criminal courts	↘ Worse	↓ Much worse	No	No
Prisons	↓ Much worse	↘ Worse	No	No

Source: Institute for Government analysis, supported by CIPFA. See table overleaf for method of categorisation.

Category	Criteria
Performance on the eve of the pandemic vs 2009/10³	Much better: Service performance (scope, quality and efficiency) on the eve of the crisis was better than in 2010
	Better: Service performance was somewhat better than in 2010
	About the same: Service performance was about the same as in 2010
	Worse: Service performance was somewhat worse than in 2010
	Much worse: Service performance was much worse than in 2010
Current performance vs 2019/20 performance	Much better: Service performance (scope, quality – including backlogs – and efficiency) is the same or better than on the eve of the pandemic
	Better: Service performance is somewhat better than on the eve of the pandemic
	About the same: Service performance is about the same as on the eve of the pandemic
	Worse: Service performance is somewhat worse than on the eve of the pandemic
	Much worse: Service performance is much worse than on the eve of the pandemic
Funding adequate to return to pre-pandemic performance levels by the end of 2024/25	Yes: Accounting for cost pressures from pay and the latest inflation, it is likely that spending since 2019/20 is sufficient to enable the service to return to 2019/20 performance levels by April 2025
	Maybe: It is finely balanced or uncertain that spending since 2019/20 is sufficient to enable the service to return to 2019/20 performance levels by April 2025
	No: It is unlikely that spending since 2019/20 is sufficient to enable the service to return to 2019/20 performance levels by April 2025
Funding adequate to maintain performance levels between the end of 2024/25 and 2027/28	Yes: It is likely that implied government spending plans for 2025/26–2027/28 will be sufficient to maintain performance at April 2025 levels
	Maybe: It is finely balanced or uncertain whether implied government spending plans for 2025/26–2027/28 will be sufficient to maintain performance at April 2025 levels
	No: It is unlikely that implied government spending plans for 2025/26–2027/28 will be sufficient to maintain performance at April 2025 levels

Cross-service analysis



Performance

Most public services are performing worse now than on the eve of the pandemic

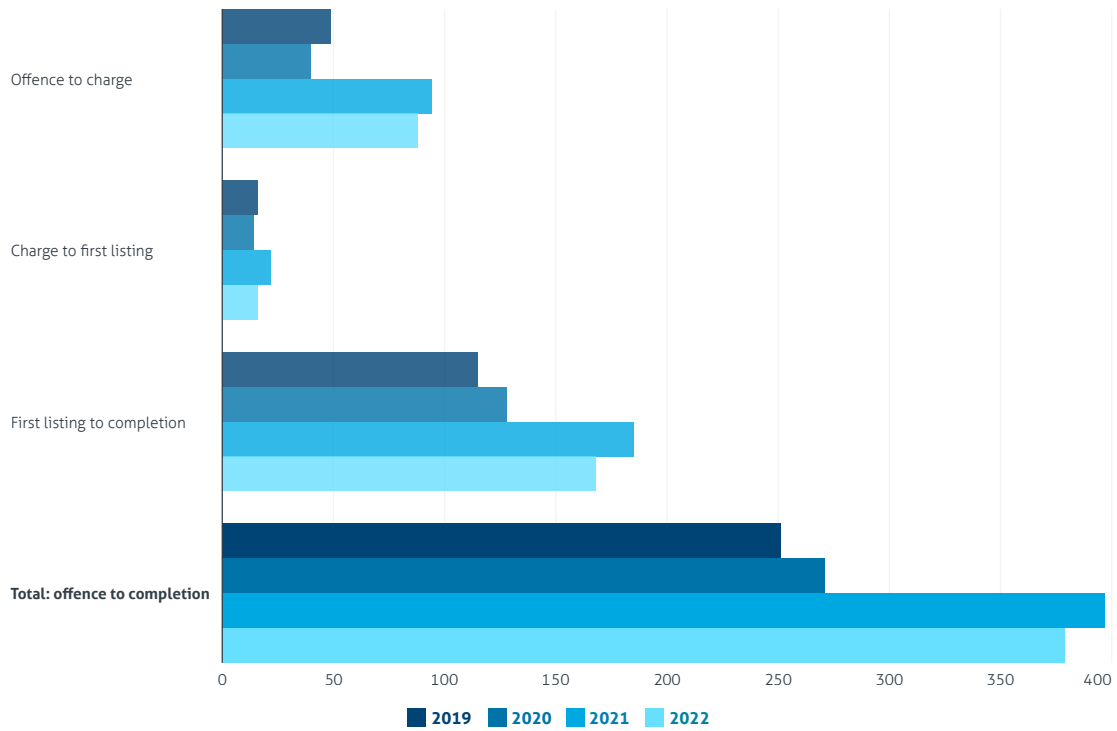
Eight of the nine services covered in this report are performing worse now than they were in 2019/20. In many ways this is unsurprising. The pandemic was an unprecedented disruption to public service delivery and placed some major new demands on services – particularly health care – and it is to be expected that the backlogs and unmet needs that arose during this period would take some time to be addressed. But the depth of problems and speed of recovery have been worse than they might have been because of the state of public services when the pandemic hit.

Indeed, previous Institute for Government and CIPFA research¹ found that of the services covered in this report, only schools were performing better than they were in 2010. The performance of all other services had fallen, with the biggest declines being seen in prisons, hospitals, general practice and adult social care. Neighbourhood services were not covered in that report, and the government lacks good performance data for most, but many of these services became harder to access in the 2010s, with fewer accessible bus routes outside London, less frequent waste collection and fewer libraries.²

While performance has worsened in most services since 2019/20, criminal courts and hospitals are in serious trouble. The crown court backlog is at a record high, reaching 64,709 in June 2023, compared to just 40,826 in March 2020. And the situation is even worse than the headline figure suggests. A disproportionate number of cases in the backlog are jury trials, which take much longer to process. Accounting for this greater complexity, the backlog is now equivalent to 89,937 cases.

As a result of the large backlog, the average wait from a case being listed to a trial being completed has risen to 168 days in 2022, up from 115 days in 2019. But the *overall* wait from offence to completion now exceeds a year – rising from 251 days to 379 days over the same period. In both cases, there has been a small improvement over the past year.

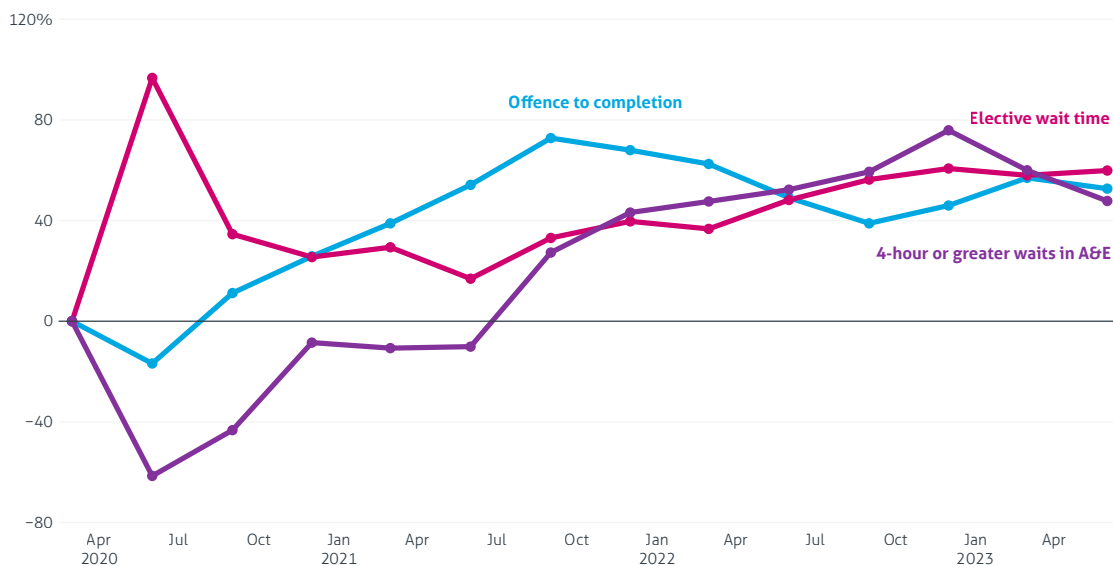
Figure 0.1 Average criminal justice system timeliness in days, 2019–2022



Source: Institute for Government analysis of Ministry of Justice, 'Criminal court statistics quarterly: April to June 2023', ('Table T4'), supported by CIPFA. Notes: Figures are medians and individual components may not sum to the overall total. See Methodology for further details.

Hospital services are also struggling badly, with people suffering very long waits for treatment. On all major performance metrics, hospitals are doing substantially worse than they were in 2019/20. In 2022/23, just over half of those attending A&E were admitted, transferred or discharged within four hours (56.7%), compared to three quarters in 2019/20 (75.4%). This is against a long-standing target of 95%, and a new target from December 2022 of 76%. The elective waiting list also continues to grow, reaching 7.8 million in August 2023.

Figure 0.2 Change in hospital and criminal justice system waits/processing time since Q1 2020



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Full time series' table), August 2023, NHS England, 'A&E attendances and emergency admissions' ('Performance' table), June 2023 and MoJ, 'Criminal court statistics quarterly: April to June 2023' ('Table T4'), supported by CIPFA.

The picture in general practice is more nuanced. Productivity appears to have improved, with a record number of appointments being delivered despite a fall in the number of fully qualified, permanent GPs. Direct patient care staff (DPC)* such as pharmacists are also providing more appointments in a wider range of services than ever. Despite this, patients are finding it harder to access primary care services, with demand easily outstripping supply.

Those who need adult social care are struggling to access publicly funded services. Large injections of funding over the past year have helped to partially stabilise the adult social care market, but staffing problems and capacity are worse than they were before the pandemic: vacancy rates in 2022/23 sat at 9.9% – an improvement on the 10.6% of 2021/22, but still well above the 6.7% in 2019/20.

Virtually all the neighbourhood services covered in this report are doing somewhat worse now than on the eve of the pandemic. There are, for instance, higher levels of rough sleeping, a continued deterioration in road quality and lower rates of recycling.

In schools, attainment in reading at key stage 2 and English and maths at key stage 4 appears to have stayed relatively steady, despite the disruption to learning caused by the pandemic. However, there has been a decline in maths and writing skills at KS2 – and there is likely to have been deterioration in other KS4 subjects besides these core curriculum ones. There is also a growing gap in attainment between disadvantaged pupils and their better-off peers. Given pupils who completed assessments in 2023 may have benefited from up to two and a half years of tutoring under the National Tutoring Programme, these results raise questions about the effectiveness of this programme. Meanwhile, many pupils' learning has been disrupted by a sharp increase in absence rates since the pandemic, with more than one in six primary school pupils (17.2%) and more than one in four secondary school pupils (28.3%) estimated to have been persistently absent in 2022-23.

In the police, the absolute number of charges fell by 13.5% between 2019/20 and 2021/22, despite the big increase in the number of officers.** Perhaps counterintuitively, the big influx of new recruits has, in fact, been a short-term drain on the productivity of forces due to the amount of supervision and support that they need. The number of charges increased by a minimum of 8.9% in 2022/23, likely reflecting new officers becoming more productive, but this is still 5.8% lower than in 2019/20. Public trust in the police is also substantially lower than before the pandemic, as a result of high-profile scandals in recent years.

In prisons, the picture is mixed. Starts and completions of accredited programmes*** in 2021/22 were down 59.9% and 64.6% respectively compared to 2019/20, meaning fewer inmates are able to set themselves up for better opportunities on release. While numbers climbed between 2020/21 and 2021/22, it is unclear whether this is indicative of the start of a long-term recovery, or simply a bounce back after the

* This includes care co-ordinators, pharmacists, pharmacy technicians, social prescribing link workers and others.

** This figure excludes some charges from 2019/20, so the fall is actually understated.

*** Intervention programmes offered to offenders, which address issues such as offending, violence and substance misuse. A full list is available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960097/Descriptions_of_Accredited_Programmes_-_Final_-_210209.pdf

initial shock of the pandemic. Rates of assault – both on other prisoners and on staff – were much lower in 2022/23 than in 2019/20, having fallen dramatically due to the pandemic. However, rates have been increasing for the last two years. Self-harm has fallen among male prisoners – who account for 96% of the prison population – but has increased substantially among women, with incidents per individual increasing by 79.3% from an already high level between 2019/20 and 2022/23.

The common factor behind these trends is that prisoners are now spending more time locked in their cells than they were before the pandemic. While that has had a positive impact on some performance indicators, like violence rates, these statistics do not tell the whole story and the overall effect is negative, with prisons less able to undertake the rehabilitative activities that are critical to their purpose.

Children’s social care is the one service that is performing at broadly the same level as it was in 2019/20. The proportion of cases seen within 15 days of a s47 assessment* improved from 78.8% then to 80.0% in 2021/22. However, the proportion of child protection plans that were reviewed within the required timescales has fallen from 91.5% to 89.3% over the same time period. Ofsted inspection results have marginally improved, but only 74 of 152 councils have been assessed since inspections resumed in 2021, making it hard to draw firm conclusions.

Public service performance problems are systemic

There are serious performance issues in each of the individual services covered in this report. But they also operate as part of wider systems,³ with problems in one service feeding into others. Such interrelated difficulties are most obvious in the health and care, criminal justice and local government systems.

Delayed discharge from hospitals of people who no longer need medical attention hampers elective and emergency activity by making it more difficult to admit new patients. This is not just felt on wards: ambulances cannot hand over patients to A&E if the system becomes jammed; and GPs find more of their referrals to hospitals are rejected or that their patients must wait longer for an appointment following a referral. And while hospitals themselves are responsible for a substantial proportion of delays – for instance, as patients suffer long waits for prescriptions or discharge plans before they can leave – many are due to a lack of capacity in adult social care and community health provision. Often, there is nowhere else to go for people who are ready to leave hospital.

Patients spending longer in hospital beds also face greater risk of losing mobility and acquiring infections, increasing demand on other health and community services. Such people may find themselves back at their GP sooner – but with demand in general practice already outstripping supply, and many unable to book timely appointments or access other support, some will instead go straight to A&E, increasing pressure on hospitals.

* Investigations carried out by local authorities to assess if there is a risk of significant harm to a child or children.

Similar systemic problems can be seen in criminal justice. The government's successful programme to increase the number of police officers by 20,000 (between 2019 and 2023) has started to feed through into more charges, in turn increasing demand on the criminal courts and, eventually, prisons. Neither has had (nor likely will have) the capacity to adequately cope with this. As a result of judge and barrister shortages, increased case complexity and declining guilty plea rates, productivity is declining in the crown court. Similarly, the growth in the prison population is expected to exceed building plans. This comes in a context in which both were already struggling to cope with demand, despite lower than anticipated case flow. The government is not on track to meet its already unambitious crown court backlog target and prisons are at bursting point, having recently been forced to rely on last-ditch population-control attempts like early releases and sentence suspensions. This comes on top of the service's reliance on temporary and police cells (and even the possibility of renting cells overseas⁴) due to delays to the prison building and refurbishment programme.

The slow progress in tackling the crown court backlog has also contributed to a 51.4% increase between February 2020 and June 2023 in the number of prisoners held on remand awaiting trial, adding to overcrowding. This has made it even harder for prisons to safely return to pre-pandemic regimes, leaving many prisoners stuck in their cells for more than 20 hours a day, with, as noted, less access to training and education than before the pandemic. Reduced provision of rehabilitative activity will likely have a knock-on effect on reoffending, which will in turn place additional pressure on the criminal justice system.⁵

In local government, councils are responsible for the delivery of a wide range of public services but have been forced to make difficult decisions in the face of reduced funding and increased demand. This is not a new problem: between 2009/10 and 2021/22, local government spending power fell by 10.2%, due to substantial cuts to the value of central government grants.⁶

At the same time, demand for adult and children's social care services has grown. Since 2015/16, the number of requests for adult social care support from new clients has increased by 22.1% for 18–64 year olds. Similarly, the number of children in care and children protection plans grew by 27.5% and 30.2% respectively between 2009/10 and 2021/22.⁷

Local authorities are subject to statutory duties requiring them to safeguard and protect vulnerable children and adults. As a result, they have had to maintain social care provision at the expense of other services. The exact balance of cuts has depended on local circumstances and political priorities, but overall spending on non-social care services fell by 30.6% in real terms between 2009/10 and 2021/22.⁸

There are also important interdependencies between health and care, criminal justice, local government and wider services. Extensive hospital waiting lists and difficulties accessing general practice have created backlogs in medical appointments for an ageing prison population, placing additional pressure on prison officers. Long waits for NHS assessments for autism and ADHD are a barrier to providing earlier formal

support to pupils with special educational needs to save costs later. And cuts to local authority funded youth services have likely placed additional crime and non-crime demand on the police.

Many interviewees also emphasised the knock-on impact of limited access to publicly funded mental health services, with particular pressure placed on hospitals, police, schools and children's social care.

Covid no longer appears to be a major, direct drag on public service performance

In the first year of the pandemic, Covid had an unprecedented impact on the performance on public services. Many paused activities completely, at least initially, while most others were forced to implement stringent social distancing requirements or deliver services remotely. In *Performance Tracker 2022: Public services after two years of Covid*,⁹ we reported that the direct impact of Covid was much reduced but still present in some cases and particularly hospitals, where enhanced infection control measures were a continued drag on productivity.

At the time of writing, the pandemic is no longer having a meaningful *direct* impact on the performance of public services covered in this report. Buildings have reopened, social distancing has been scrapped and the NHS is no longer taking onerous additional precautions to protect against Covid infections.

There are, however, lingering indirect effects, most notably on staff, whose absence rates have remained much higher than pre-pandemic. In prisons, the number of working days lost to sickness among main operational staff was a quarter above the 2019/20 level (24.3%), even if slightly down on the previous year. In hospitals the proportion of available staff days lost to illness increased from 4.46% in 2019/20, to 5.36% in both 2021/22 and 2022/23 – an increase of nearly 20% across the two years.¹⁰ In children's social care, the sickness absence rate is lower, at 3.5% in 2022, but that is still the highest since 2017 and up on 2.9% in 2020 and 3.1% in 2019.

Historic underinvestment in capital has hit public services hard

Covid is no longer having a direct impact on services – but problems persist. This is because while the pandemic was a serious shock, it also exacerbated and magnified pre-existing problems – most importantly, the historic underinvestment in capital and difficulties with recruitment and retention.

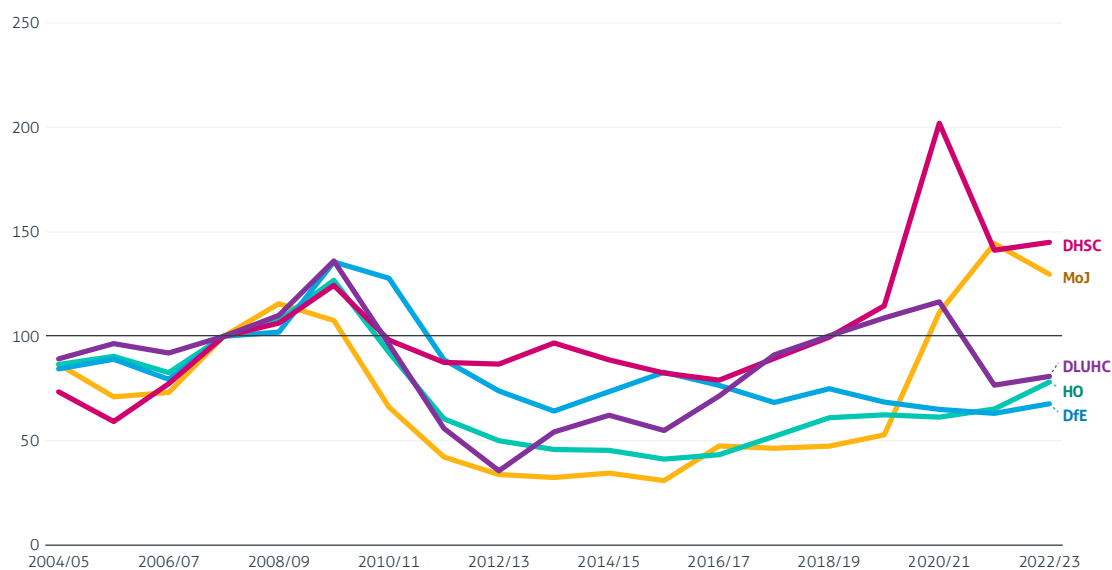
Compared to other rich nations the UK is a low-investment nation. According to analysis by the Resolution Foundation, UK government investment* has averaged around 2.5% of GDP since the year 2000, just two thirds of the OECD average of 3.7%. Indeed, the UK has consistently invested less than the average since at least 1960.¹¹ Looking at health capital specifically, since 1970 there have only been two years when the UK spent more than the OECD average and in most it spent substantially less.¹²

* General government gross fixed capital formation

The pandemic came at a particularly bad time for the UK’s public sector. The decade before saw particularly deep cuts to the capital spending of the departments overseeing the services covered in this report. The worst hit was the MoJ, where annual capital spending averaged less than half the real-terms spending in 2007/08. Capital spending by DLUHC, HO and DfE all remain substantially below the levels of 2007/08. Even DHSC, which was relatively protected, saw cuts averaging around 8%. Capital spending by DHSC and MoJ grew substantially in 2020/21, but it will take time to undo the effects of historic low investment.

If the government had wanted to keep capital spending the same as the average between 2004/05 and 2007/08 for the whole of the 2010s for the departments covered in this report, it would have needed to spend an additional £24bn throughout that decade, in 2023/24 prices – about 12% more than the government actually spent in that time. But even that sum is equivalent to only around two thirds of the maintenance backlog across the services for which data is published (see below), reflecting that even between 2004/05 and 2007/08 capital spending was still not particularly generous.

Figure 0.3 **Capital spending index, public service departments, 2004/05–2022/23**
(real terms, 2007/08 = 100)



Source: Institute for Government analysis of HMT, *Public Expenditure Statistical Analyses*, 2009–2023, supported by CIPFA. Notes: ‘DLUHC’ refers to DLUHC community capital spending, and excludes DLUHC spending on housing services.

In addition to receiving relatively ungenerous capital budgets, departments have consistently underspent, for a variety of reasons. Government suffers from persistent ‘optimism bias’ over how long projects will take to complete. There is insufficient capacity in the construction sector to deliver. And cuts to administrative budgets have reduced departments’ ability to spend quickly and well.¹³ Some departments have used capital budgets to cover shortfalls in day-to-day spending: between 2014/15 and 2018/19, some £4.3bn of funding initially allocated to health capital was transferred in this way¹⁴ to meet “spending pressures”.¹⁵

This has all had a serious impact on the productivity of public services, with problems with both the quality and quantity of capital assets. Teachers, nurses, doctors and social workers all find it harder to do their jobs in crumbling and cramped buildings, on old computers running out-of-date software, and without access to the latest equipment.

Sizeable maintenance backlogs have built up in some services. Across the hospitals, schools, criminal courts, prisons and the road network this now totals £37bn;^{*16,17,18,19,20} in prisons, this has contributed to the shortage of cells and the need to make emergency use of police cells to hold inmates. Prisons are now so full that maintenance projects have been further delayed as governors cannot afford to move people out of substandard cells while they are repaired. In the NHS, almost a fifth of the record maintenance backlog is classified as 'high risk' (17.6%), which means repairs must be carried out urgently to avoid "catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution".²¹ Similarly, tight capital budgets have prevented departments from replacing buildings constructed using reinforced autoclaved aerated concrete (RAAC), some of which are now considered too dangerous to use. For example, in 2020 DfE requested funding to rebuild and refurbish around 200 schools a year but was only granted funding for a quarter of that.²²

Many public services are using technology that is not fit for purpose. In the criminal courts, a recent survey found less than half of salaried and fee-paid judges said that internet access at court was excellent or good.²³ And Institute for Government research published earlier this year heard from interviewees about the impact of "slow-loading computers and creaking internal systems" on NHS performance.²⁴ Up to 27 out of 220 trusts rely on paper as they still do not have electronic patient records²⁵ and efforts to improve IT have been undermined by cuts to capital funding.²⁶

The NHS is also short of critical equipment. Among OECD countries, the UK has the fifth lowest number of CT and PET scanners and MRI units per capita.²⁷ As a result, hospitals are able to conduct fewer diagnostic tests, extending the size of the elective backlog and waiting times for patients.

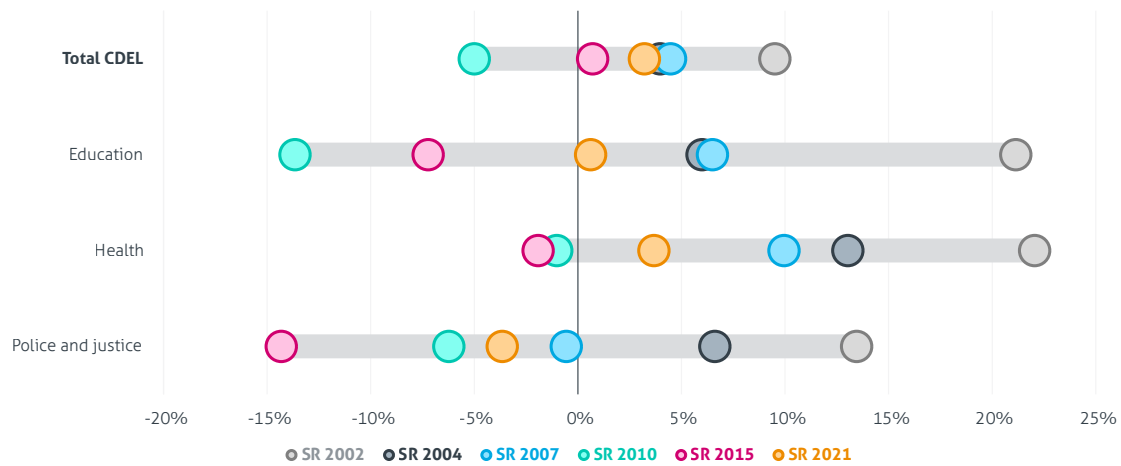
Taken together, this underinvestment means that public services are getting less out of each member of staff than they would otherwise. This partly explains the 'productivity puzzle' seen in the NHS, and particularly hospitals²⁸ – that is, why extra cash funding has not helped boost activity as hoped.

The government has recognised the importance of capital investment, with Jeremy Hunt, the chancellor, saying in the autumn statement 2022: "When looking for cuts, capital is sometimes seen as an easy option. But doing so limits not our budgets but our future."²⁹ To that end he announced that capital allocation made in 2021 would be protected for the spending review period, and would then be maintained in cash terms for the following three years. This includes funding to expand and improve the prisons, hospitals and schools estates.^{30,31}

* £10.2bn in hospitals, £10.6bn in school, £1bn in criminal courts, £1.4bn in prisons, £14.0bn across the road network.

Despite higher inflation eroding the value of the 2019 settlement, capital budgets for this spending review period are still set to grow more quickly than during the multi-year spending reviews in the 2010s. However, this is from a relatively low base, and below the growth rates seen in the 2000s.

Figure 0.4 **Average annual real-terms change in planned capital spending at successive multi-year spending reviews, 2002–2021**



Source: Institute for Government analysis of successive HM Treasury multi-year spending review documents, supported by CIPFA. Notes: Figures adjusted based on the GDP deflator forecast at the time of each spending review.

High turnover and loss of experienced staff have further hampered services

Workforce turnover can help to improve services by bringing in new staff with different backgrounds and experiences. But the evidence suggests that the high rate of churn in many public services is damaging service productivity and can lead to worse outcomes for services users³² – for example, students’ test scores are reduced by higher teacher turnover.³³

Leaving rates are high across all public services. In the 12 months to June 2023, one in ten workers left NHS hospital and community care settings (11.2%). Although this is below the highs of 12.5% in the year to summer 2022, during the second year of the pandemic, it is still above 2019 levels. And in children’s social care, 17.1% of the workforce left in the last financial year – a series high – up from 15.1% in 2019/20. It may be that higher leaving rates partly reflect the loss of staff who would have left in 2020/21 but stayed longer due to the pandemic; if so, leaver rates could return to pre-pandemic levels. But for now they remain elevated in many services.

Many of those who have left public services roles had years of experience – and were therefore likely to be among the most effective in their roles.³⁴ For example, half of band 3–5 prison officers in 2022/23 have fewer than five years’ experience, compared to 23% in 2009/10, while the proportion with more than 10 years’ experience fell from 56% to 31% over the same period. And in nursing, the overall

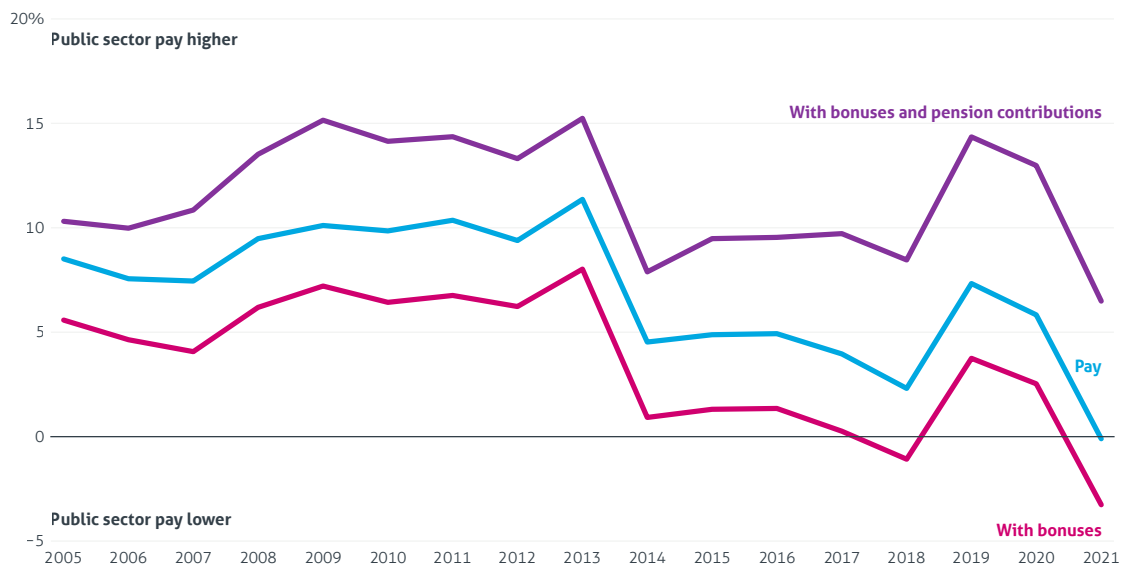
* In the case of prison and police officers, large numbers of experienced staff left in the early 2010s through voluntary redundancy schemes introduced by the coalition government to cut staff as part of efforts to reduce public spending.

Many of these are long-running problems. In the 2010s, the government made 'efficiencies' by holding down public sector pay. Previous Institute for Government and CIPFA work has estimated that the two-year pay freeze between 2011 and 2013, and a 1% average pay cap from 2013 to 2017, saved the government £10bn–£20bn

per year from 2017 onwards.⁴¹ However, as a result the public sector pay differential – the difference between public and private sector pay – fell substantially and, taking account of bonuses, turned negative.

Once employer pension contributions are taken account of, total public sector remuneration was still higher, but in 2021 the gap was the smallest it had been since at least 2005. More recently, public sector wages have been further eroded by high levels of inflation, meaning the gap is likely to have shrunk further.

Figure 0.6 **Average public–private sector pay differential, 2005–2021**

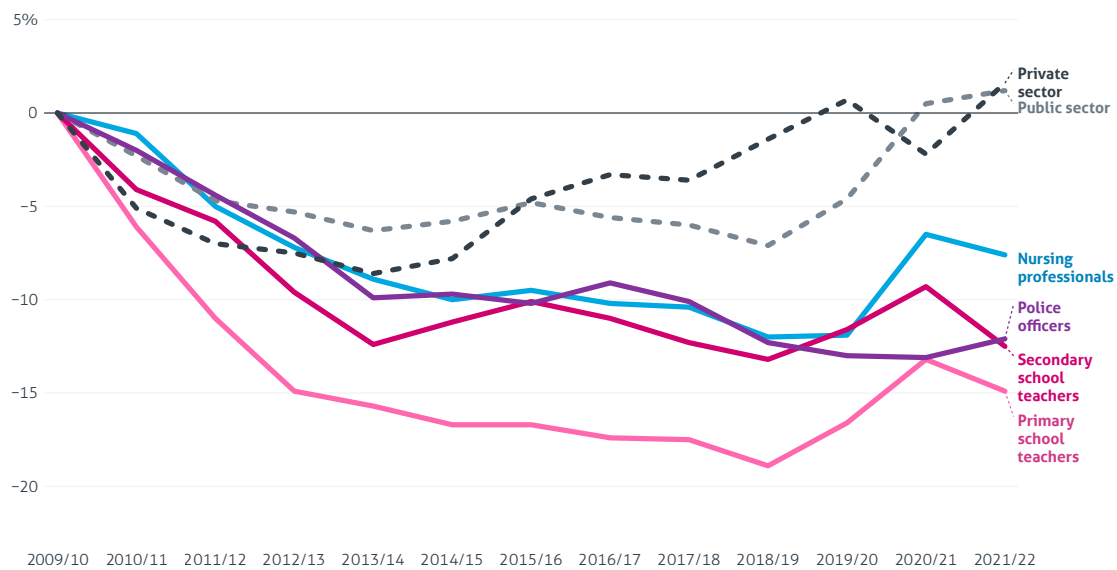


Source: Adapted from Institute for Fiscal Studies, 'Public spending, pay and pensions' ('Figure 4.15'), October 2022, supported by CIPFA. Notes: This controls for differences in factors such as age, sex, and region. This is an hourly measure. Figures are estimates and are subject to some degree of sampling error.

As a result, pay for critical public service staff such as police officers, teachers and nurses has not kept pace with private sector wage rises, and is also worth less in real terms.* Unsurprisingly, staff are unhappy. For example, the proportion of respondents to an annual Police Federation survey reporting dissatisfaction with basic pay increased from 69% in 2020 to 86% in 2022.⁴² And the latest NHS staff survey found only 25.6% of staff were satisfied with pay, 12.3 percentage points lower than in 2019.⁴³ In addition to its contribution to high leaving rates, pay is also the key driver of strike action (discussed in more detail below), which is also hugely disruptive to public services.

* This is also true if 2008 is taken as the starting point, though the difference is smaller as public sector wages outperformed those in the private sector between 2008 and 2010.

Figure 0.7 **Change in median gross earnings of selected public sector professionals since 2009/10 (real terms)**



Source: Institute for Government analysis of ONS, 'Earnings and hours worked, occupation by four-digit SOC' ('ASHE Table 14'), supported by CIPFA. Notes: Figures have been deflated using OBR CPI figures. Figures for primary education teaching professionals include nursery staff up to 2020/21. Figures for nursing professionals uses data for health associate professionals for 2009/10, nursing and midwifery professionals for 2010/11–2019/20 and nursing professionals for 2020/21–2021/22.

On workloads, while many public service jobs have always been demanding, there is evidence that the pandemic has increased workloads even more,⁴⁴ and excessive workloads are cited by many who are considering leaving. For example, “feeling under too much pressure” was the second most common reason given by nurses for thinking about or planning to leave their role.⁴⁵ And research by the Department for Education found that workload was given as a reason by almost all teachers considering leaving the state sector in the next 12 months for reasons other than retirement (92%).⁴⁶

Public services can also involve unsociable hours, particularly those such as hospitals and the police, which run 24 hours a day, all year round. These services require staff to work in shift patterns, which likely contributes to many staff reporting low levels of wellbeing. For example, only a little over half of respondents to the NHS Staff Survey said they have balance between home life and work life,⁴⁷ and just under half of police officers reported they have poor work–life balance.⁴⁸ In comparison, a survey of 2,000 UK employees published in 2022 found that only 31% did not feel that they have a good work–life balance.⁴⁹

Such working patterns are increasingly unattractive given changing societal norms. Particularly for graduate roles, home and ‘flexi’ working arrangements have also become much more common in other sectors and a failure to keep up with the wider economy has left many public service employers at a comparative disadvantage.⁵⁰ This desire for greater flexibility is behind the decision by some nurses and doctors to take up agency or locum roles, rather than direct NHS employment.⁵¹

These factors, particularly pay and poor working conditions, have contributed to a loss of goodwill among public service workforces, with many giving this as a key reason for quitting. For example, of nurses planning to leave, 70% cited feeling undervalued.⁵² Similarly, morale (98%) and how the police are treated by the government (96%) were the top two reasons given by police intending to resign.⁵³

These issues are particularly problematic given the tightness of the labour market. Across the wider economy, there are more vacancies than job seekers,⁵⁴ meaning employers have to do more to retain and recruit staff. We heard in interviews that many public services are struggling with competition from the private sector – and elsewhere in the public sector. Better pay or working conditions in the retail and hospitality sectors has tempted away many working in lower paid public service roles, including care workers and administrators. Public sector employers similarly find it difficult to compete with the private sector wages available to managers, analysts and IT professionals.

Within the public sector itself, worse remuneration packages in adult social care, prisons and community pharmacies have resulted in a net loss of staff to the NHS, police and primary care respectively. Competition also comes from overseas, particularly for doctors and nurses, where the higher pay and standard of living available has seen many move to countries such as Australia, New Zealand and Canada.

The government is relying on immigration to fill workforce gaps in some services

There has been a substantial increase in the number of international recruits starting in general practice, hospitals and adult social care – all services that have experienced some form of workforce crisis since the pandemic. Most strikingly, in the 12 months to June 2023, the number of British nurses and health visitors fell by 2,763, while the number from the rest of the world increased by 11,984.⁵⁵ And in adult social care, new joiners from overseas over the past year alone account for 3.6% of all filled posts in the sector.

International recruits can improve public services by bringing different ways of working and perspectives, but relying on them to fill workforce gaps comes with risks. First, international staff are generally more expensive to recruit. Research by Nuffield Trust found that it costs £10,000–£12,000 to recruit a single nurse from overseas. However, this does mean that the government avoids the training costs for these staff. This can be much higher; for example, the typical cost of training a nurse domestically is at least £26,000.⁵⁶

Second, those recruited may not stay in their roles as long. While international nurses from outside the EU are more likely to stay in the NHS as a whole and in the same organisation than those from the UK, those from the EU leave more quickly.⁵⁷ Internationally recruited doctors also stay in the service for less time than their British counterparts.⁵⁸ This leads to greater staff churn and higher recruitment costs per year served.

Third, there is a political risk. International recruitment, particularly of care staff, has been a major contributor to the record levels of net migration over the last year. Given the high public salience of immigration levels,⁵⁹ and the Sunak government’s rhetoric around immigration, there is a risk that these recruitment routes are shut down, possibly at short notice, allowing little time for providers to identify new sources of staff. Even if high levels of international recruitment remain possible, public services in this country have no control over the numbers trained abroad, how competitive the global marketplace is, or the occurrence of shocks such as Covid that can disrupt the ability of people to move between countries.

Widespread strikes have had a negative impact on public service performance

Public services are facing the greatest level of disruption from strikes in more than a quarter of a century. From August 2022 to July 2023, more than 2 million working days were lost due to strike action in the public sector. This is the most in a 12-month period since at least 1996, when comparable statistics were first published.⁶⁰

Figure 0.8 **Working days lost to strike action in the public sector over the previous 12 months, December 1996 to July 2023**

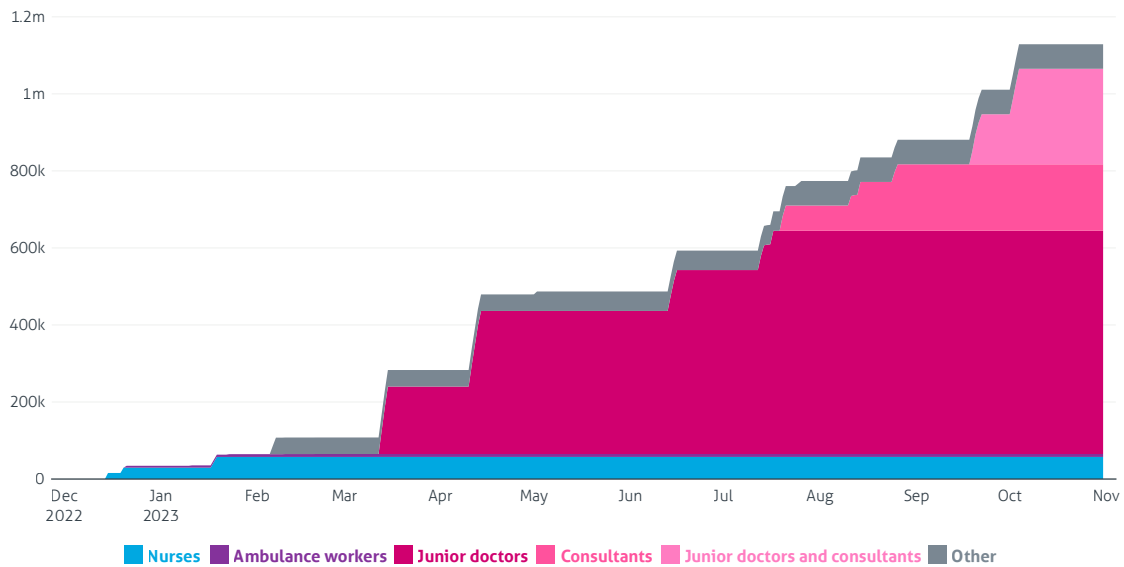


Source: Institute for Government analysis of ONS, ‘Labour market statistics time series’, September 2023, supported by CIPFA.

Strikes of this magnitude have a big impact on the performance of public services. Academic research looking at strikes by doctors in 2016 found that the disruption did not have an impact on patient volumes, average mortality or readmission rates for emergency patients. However, there were higher readmission rates for Black patients and reductions in the volume of elective procedures.⁶¹ While it is still too early to fully assess the impact of NHS strikes over the past 12 months, it does appear that the strikes by junior doctors in April 2023 led to a meaningful fall in the number of elective procedures.

Hospitals completed 1.4 million elective pathways in April 2019, but only 1.2 million in April 2023 – 10.4% less. As a result, the elective backlog increased by 84,166 in that month. And in the following month, when there were no strikes by junior doctors, the number of completed pathways rebounded to 1.5 million.

Figure 0.9 **Cumulative elective procedures rescheduled due to strike action, December 2022 to July 2023**



Source: Institute for Government analysis of NHS England, 'Potential industrial action in the NHS – impact of various strike actions', 2022 and 2023, supported by CIPFA. Notes: This data can both overstate and understate the number of distinct procedures affected: one elective appointment can be rescheduled multiple times, but hospitals also start to not schedule appointments during strike periods.

A similarly clear drop in activity can be seen in schools. According to data published by the Department for Education, as little as 43% of pupils attended school during the eight days of national teacher strikes that took place between February and July 2023. Secondary schools were struck particularly hard, with only around a quarter of pupils going into school on strike days.⁶² The absence of so many pupils for more than a week this academic year will only make it harder for schools to catch up on learning lost during the pandemic.

The industrial action by criminal barristers between April and October also reduced the activity that criminal courts were able to undertake. The number of cases processed in crown courts fell from 25,172 in March 2022 to 20,068 in September 2022, again hurting backlog reduction efforts.

The government’s strikes strategy likely extended the strikes, and so their disruption

The widespread strike action over the past year has deep and broad roots, including the coalition government’s decision to hold down public sector pay from 2011 onwards (Figure 0.7), the more recent spike in inflation, and the impact of the pandemic on services and staff wellbeing. Given the UK’s low economic growth, high levels of debt and inflation, and the need to consider the impact of pay offers to some groups on the demands of others, any government would have found it difficult to resolve these industrial disputes.

However, there were important weaknesses in the Sunak government's strategy for responding to strikes, which likely extended their duration and thus the level of disruption caused to public services. Most critically, ministers refused to negotiate on pay for months. Strikes by NHS staff, including nurses and paramedics, began in December 2022, teachers from the National Education Union in February 2023, and junior doctors in March. This followed months of campaigning and balloting by the unions involved. But it wasn't until March that an improved offer was made to NHS staff and teachers (with the schools pay dispute only resolved after a further, improved offer), and junior doctors' pay was eventually raised unilaterally in July, when the government accepted recommendations made by pay review bodies.

For too long the government unreasonably claimed that higher pay was not possible due to the impact on inflation. However, there is no evidence that improved offers below the consumer price index (CPI) but closer to private sector wages would have any impact on inflation.⁶³ Indeed, the government eventually made offers at this level. If it had done so earlier – in autumn 2022, rather than spring 2023 – it may have been able to bring at least some of the disputes to an end with far less disruption. Instead, the government's combative approach, including the introduction of the Strikes (Minimum Service Levels) Act, probably exacerbated resistance from strikers, making it even harder to reach agreement.

The same is true of the dispute with criminal barristers that was resolved in 2022. Little progress was made by Dominic Raab while he was justice secretary, yet Brandon Lewis, who took a much more conciliatory approach, was able to end the strikes by making an improved pay offer, despite only being in post for six weeks.

Of all the disputes, the one with junior doctors looks most difficult to resolve. The British Medical Association is seeking a 35% pay rise (to bring pay back in line with 2008/09 levels) and there has been little evidence that it is willing to negotiate substantially down from this. Despite the relatively low cost of meeting this demand,⁶⁴ it would have been difficult for any government to do so given the knock-on impact on the (more modest) pay demands of less well paid NHS staff.

However, even in this case, a different approach by government may have helped. With a more moderate and reasonable public stance, the government could have garnered greater public support, putting pressure on junior doctors to compromise and on consultants* not to join them on the picket line in July. Instead, public support for junior doctors grew from 47% in January to 56% in June.⁶⁵

* Consultants, while still in dispute with the government, have offered not to conduct further strikes if the government will agree to talks facilitated by ACAS, <https://www.bma.org.uk/bma-media-centre/bma-offers-government-route-to-resolve-consultants-dispute-via-acas>

Workforce problems will prevent some services returning to pre-pandemic performance levels by the end of the current spending review period in April 2025

Staffing is the single biggest expenditure for public services, accounting for more than half of spending for most of the services covered in this report. While there are a variety of ways that government could improve the performance of services, absent major productivity improvements, the size and composition of workforces will be a key factor.

Policing is the only service covered in this report for which the workforce should enable a return to pre-pandemic performance levels by April 2025. Though there remain shortages in key positions, such as investigators, and the number of PCSOs has fallen, the number of police officers has increased by more than 20,000 and by April 2025 many of these recruits should be more effective and be contributing to better police performance, particularly in terms of the number of charges. Indeed, the recent reversal in the long-term trend of falling charges may be early evidence of this.

At the other end of the spectrum, prisons, criminal courts and children's social care do not have plans in place that will lead to sufficient recruitment or retention of staff. The problem is most severe in prisons. Most critically, there is no credible plan in place to recruit the number of officers needed to safely staff the huge expected increase in prisoners over the next few years due to the greater police numbers cited above; this will also affect courts, in which the current workforce of judges and barristers is likely to be insufficient to process a substantially higher volume of cases in the crown court.

Demands on children's social care services are rising but the number of children's social workers fell over the past year. With evidence that caseloads are becoming more complex, workloads already becoming unmanageable for many – and in the absence of a workforce strategy to ease pressure on staff – it appears highly unlikely that this workforce will be sufficient to meet demand.

The workforce situation in the other services is less clear. However, although strike action is only ongoing in hospitals, the ability of the government to agree future pay deals will have a big impact on recruitment and retention across all the services covered in this report. The ease of doing that will depend on inflation and the health of the wider economy.

Funding

Funding settlements are now worth less due to higher pay awards and inflation

Budgets for the 2022/23–2024/25 period were originally set at the 2021 spending review. Additional funding for the NHS, schools and adult social care was then announced at the 2022 autumn statement. However, the value of these cash settlements has been eroded over time, due to higher than anticipated pay awards and inflation.

The 2021 spending review anticipated that public sector wages would increase by 2–3% annually across the spending review period. However, the government has been forced to make substantially higher pay awards as a result of inflation and industrial action, as covered above. For example, the cost of the improved offer to nurses, ambulance staff and other NHS workers (those on the Agenda for Change pay scale)⁶⁶ was an additional £2.7bn in 2022/23 and an approximate ongoing cost of £1.3bn per year from 2023/24 onwards.⁶⁷ In March, when this deal was agreed, the government did not state how it would be funded.

In July, when the government accepted the recommendations of pay review bodies (PRBs) for other public service workforces, it said it would not borrow to fund these. This means that these will have to be paid for either through increased revenue, or by cutting spending. The government has stated that some of the funding will come from increases to visa fees and the immigration health surcharge.⁶⁸ However, most will come from reallocating existing spending, either from within departmental budgets or elsewhere across government.

The increase in teachers' pay will also be funded from the existing DfE budget for 2023/24 and 2024/25, with the government stating that this is to come from reprioritisation of underspends⁶⁹ – expected to be partly from the National Tutoring Programme – rather than cuts to school budgets. This use of a one-off allocation to fund an ongoing liability will store up problems for the next spending review.

At the time of the 2021 spending review, the OBR projected that the GDP deflator (the measure of inflation used by the government to assess real-terms increases in departmental spending) would be 2.2% in 2023/24. By the 2022 autumn statement this had risen to 3.2% and the latest forecast from the OBR is that it will be 2.5% – though this is likely to prove too low as inflation has recently proved more persistent than expected in March 2023. As a result, spending allocations are now less generous than they were (see Figure 0.10).

Some services are facing even higher sector-specific inflation than this. Interviewees told us that the unit costs of adult social care packages are now much higher than they were a year ago. According to a survey of directors of adult social services, this has been driven by increasing complexity of care needs, staffing costs and wider inflationary pressures.⁷⁰ Similarly, we heard that the unit cost of residential children's social care placements has also risen substantially, with increased demand and limited capacity putting local authorities in a weak bargaining position with private providers.

The inflation-driven rise in interest rates could also reduce spending on local authority-provided public services. In recent years, some local authorities took out loans to finance commercial investments, hoping that those would then generate a future stream of income.⁷¹ Those with variable-rate or short-term loans that need to be refinanced will face higher interest rates, increasing annual repayments, and reducing the funding available to front-line services. Some private sector providers will also be affected. The Competition and Markets Authority has identified that some of the largest providers of residential care services for children are owned by private equity firms and carry high levels of debt. This risks a “disorderly failure of highly leveraged firms” that could affect the placements of children in care.⁷² The loss of these providers could push up prices even further.

Parts of local government and the NHS are already running deficits

According to government figures, local authority usable reserves in England increased from 45% of service expenditure in 2019/20 to 63% in 2021/22. However, data issues mean that some councils’ reserves are likely overstated⁷³ and the precise figures depend on how the distribution of emergency business rates relief at the beginning of the pandemic is accounted for.

Comprehensive data on reserves in 2022/23 will not be published until the end of this year. However, there is extensive evidence that many local authorities have run large deficits in recent years. For example, Kent County Council overspent its 2022/23 budget by £44.4m, with the additional money coming from reserves.⁷⁴ Bradford Metropolitan District Council overspent by £32m in 2022/23, largely due to higher-than-expected children’s social care costs. The council’s director of finance noted that remaining reserves would likely only be sufficient to cover 2023/24 and that “reserves are reducing at an unsustainable rate.”⁷⁵ In this financial year, Kirklees Council has agreed to draw down £25m from reserves to partially fill a £43m budget deficit,⁷⁶ and East Sussex County Council is spending £5.6m from reserves on road repairs.⁷⁷ Reserves can only be used once and are not a long-term solution to persistent deficits.

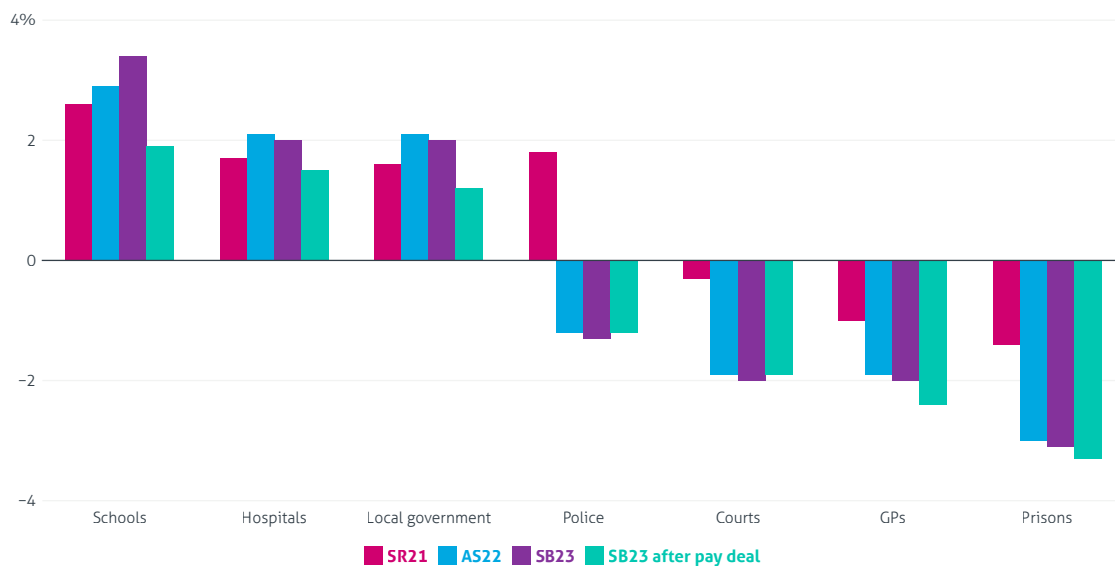
Three quarters of local authorities also had cumulative deficits on the part of local authorities’ education budgets reserved for schools spending in 2021/22, largely as a result of their spending on statutory special educational needs and disabilities (SEND) support, with the combined deficit totalling £1.4bn.* Local authorities with large deficits can access funding from central government through ‘safety valve’ deals. In exchange for additional funding, local authorities are required to eliminate their in-year deficits by taking action to reform their SEND provision – which in some cases can include moving learners from the independent special school sector, where the cost is higher, to state provision. Since 2020/21, some 34 local authorities have entered into such agreements, with the DfE committing nearly £1bn in return.⁷⁸

In the NHS, at least 14 integrated care systems (ICSs), out of a total of 42, ended 2022/23 with a budget deficit.⁷⁹ Many will run a deficit in 2023/24 as well. At the July meeting of the NHS England board, the chief financial officer reported that 15 had submitted a deficit plan for 2023/24, with a total forecast overspend of £720m.⁸⁰

* In December 2022 the government announced that local authorities could keep these deficits off their balance sheets until 2025/26, <https://www.lgplus.com/services/children/send-deficits-kept-off-budgets-for-another-three-years-12-12-2022>

Most services have not had adequate funding to return to pre-pandemic performance levels by April 2025

Figure 0.10 Average annual real-terms change in spending between 2021/22 and 2024/25 relative to demand under different inflation scenarios



Source: Institute for Government analysis of HMT, *Spending Review 2021*; HMT, *Autumn Statement 2022*; and HMT, *Spring Budget 2023*, supported by CIPFA. Notes: SR = spending review. SB = spring budget. AS = autumn statement. 'SB23 after pay deal' accounts for pay deals in 2022/23 and 2023/24 and assumes pay increases in line with economy-wide earnings in 2024/25. Police outturn in 2021/22 was higher than forecast, making the rest of the period look less generous. Full details on data sources are provided in the Methodology chapter.

Funding for general practice is insufficient to return the service to pre-pandemic performance levels. The current five-year GP contract started in 2019/2020 and runs until 2023/24, but higher than anticipated inflation means that real-terms core funding for GPs will be 3.1% lower in 2023/24 than in 2019/20, despite patient numbers registered with general practice increasing by 5.7% over the same period. There has also been underinvestment in general practice capital, which is a major impediment to expanding access to the service and also means that the successfully expanded direct patient care workforce is not being used effectively.

In contrast to general practice, spending on hospitals has increased substantially since 2019/20, with a further £3.3bn for each of 2023/24 and 2024/25 announced at the 2022 autumn statement. As shown in Figure 0.10, spending has outpaced demand and should, in theory, be sufficient to enable hospitals to return to pre-pandemic performance levels. However, the shock of the pandemic, combined with pre-existing problems such as underinvestment in capital and loss of experienced staff, has reduced hospital productivity.⁸¹ The government does not have credible plans in place to improve hospital productivity, so planned spending will not be enough.

We assess the financial sustainability of adult social care, children's social care and neighbourhood services together, as all are delivered by local government. Like the NHS, local authorities received a funding boost at the 2022 autumn statement in the form of increased funding for adult social care. As a result, local authority spending power is now projected to rise by 4.7% in real terms per year on average in 2023/24 and 2024/25. In addition to outpacing inflation, the funding increase should be

enough to meet ongoing demographic demand and maintain performance at current levels. In children's social care, that will mean performance in April 2025 will be broadly similar to that seen before the pandemic. However, in both adult social care and neighbourhood services, where performance has declined over the past three years, the funding is unlikely to be enough to see a sufficient improvement. These judgments are in aggregate and the situation will vary widely across the country due to differing demands, local priorities and effectiveness, and the ability of local authorities to raise council tax in line with central government expectations.

Schools also did well out of the 2022 autumn statement, receiving an additional £2bn in both 2023/24 and 2024/25. The typical school is in a relatively stable financial position, at least compared to most of the services covered in this report, and schools will be able to draw on extra DfE funding to cover the cost of the higher teacher pay offer in this spending review period. While there is limited evidence on the impact of the pandemic on attainment at key stage 4, the drop in pupil attainment at key stage 2 has been sizeable. Inadequacies in the design and funding of the government's catch-up programmes mean it is unlikely that this drop in performance will be reversed before April 2025.

Police forces were provided no additional funding in the autumn statement 2022, and across the three-year spending review period we calculate that demand will rise by 1.7% for police services, while spending (following the newly agreed pay deal and the government's additional funding to pay for the deal) will fall by 2%. However, the police received a substantial boost to funding in the three years before this. As a result, overall spending is expected to rise on average by 0.7% per year in real terms between 2019/20 and 2024/25, which should be enough to allow the police to return to pre-pandemic performance.

The situation in criminal courts and prisons is much harder. Like the police, they were not provided additional funding in the autumn statement 2022. However, their settlements in earlier years were also less generous. Demand for these services is also likely to rise more quickly due to the increased number of charges that 20,000 additional police officers have started – and will likely continue – to generate. Over the spending review period, we calculate that the growth in demand for criminal courts and prisons will outstrip the growth in funding by 5.0 and 4.1 percentage points per year respectively.

Funding in the next spending review period is even tighter and would see almost all services performing worse in 2027/28 than on the eve of the pandemic

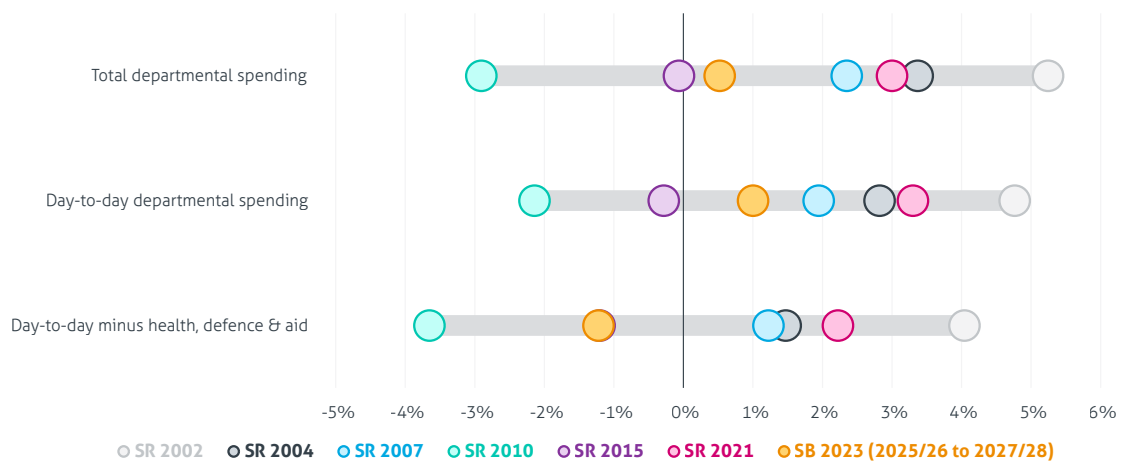
The funding situation for public services will be difficult for the rest of this spending review period, but the situation from April 2025 onwards will be even harder.

The plans set out in the 2022 autumn statement and the 2023 budget show that total departmental spending is due to grow by 1% per year in real terms between 2025/26 and 2027/28. However, assuming that NHS spending grows at 3.6% per year in real terms over this period – an amount the Institute for Fiscal Studies estimates would be required to meet the commitments laid out in the *NHS Long Term Workforce*

*Plan*⁸² – that aid spending and defence spending grow in line with GDP, and that the government will continue to allow local authorities to raise revenue through council tax increases, the settlements for unprotected areas of public spending will be much less, averaging -1.2% per year in real terms.

This would make it the tightest spending review since 2015. Notably, the Cameron and May governments found it impossible to stick to those 2015 plans.⁸³ Instead, they felt it necessary to provide additional funding to the NHS, adult social care and the criminal justice system due to poor performance. In 2025, the performance of most of the services covered in this report will be much worse than it was a decade earlier. The next government is therefore likely to face huge public and political pressure to provide public services with more generous funding settlements. Indeed, speaking at an Institute for Government event, Lord Gus O’Donnell, the former cabinet secretary, said that the spending plans were “totally unsustainable”.⁸⁴

Figure 0.11 **Average annual real-terms change in spending planned at successive multi-year spending reviews, 2002–2021**



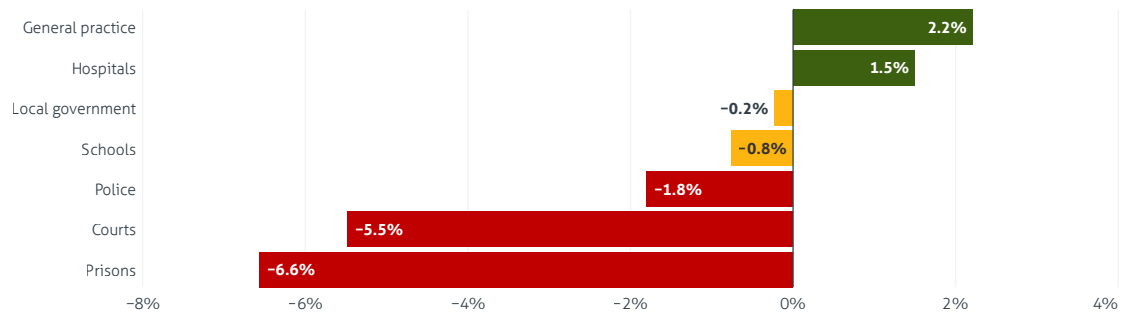
Source: Institute for Government analysis of successive HM Treasury multi-year spending review documents. Notes: SR = spending review. SB = spring budget. Figures adjusted based on the GDP deflator forecast at the time of each spending review. ‘Day-to-day minus health, defence and aid’ excludes DH/DHSC spending, MoD, and DfID spending up to SR 2021 and FCDO spending in SR 2021 and SB 2023. ‘SB 2023’ refers to the spending path set out at the 2023 spring budget.

Some services will fare better than others under current spending plans. GPs and hospitals will see a meaningful improvement in spending, largely because the government will need to raise spending on the NHS to meet the commitments laid out in the *NHS Long Term Workforce Plan*.⁸⁵ Those increases – if the government sticks to them – are likely to outstrip inflation and the increase in demand for those services.

In local government and schools the situation is less certain. Funding is around what might be needed to meet inflation and demand pressures, though for different reasons. Local authorities will continue to benefit from central government’s policy of allowing them to raise council tax, while demand for school places is expected to decline as the number of children falls in coming years, as the end in 2013 of a baby boom is felt across the education system.

Under current plans, the criminal justice system looks to have the lowest levels of funding compared to its needs. Expected demand for police, prisons and criminal court services far outstrips the funding currently implied by the government’s plans.

Figure 0.12 **Average annual real-terms change in spending between 2024/25 and 2027/28 under current government plans relative to demand**



Source: Institute for Government analysis of HMT, *Spring Budget 2023* ('Table 2.1: Resource departmental expenditure limits (DEL) excluding depreciation'), supported by CIPFA. Notes: 'Local government' covers neighbourhood services, children’s social care and adult social care. 'Unprotected RDEL' relates to areas of spending other than health, foreign aid and defence, where the government has committed to spending increases.

Given the current performance of services, the expected trajectory over the rest of the current spending review period and the spending plans discussed above, children’s social care is the only service we analyse that is likely to have sufficient funding to exceed pre-pandemic performance in 2027/28. Unlike children’s social care, the other local government services – adult social care and neighbourhood services – are performing worse than on the eve of the pandemic and the tightness of implied local government funding is unlikely to be enough for that position to be reversed. The same is true of schools, where funding is probably insufficient to make up for lost learning due to Covid.

In hospitals and general practice, increased funding in the next spending review is unlikely to reverse many of the trends – underinvestment in capital, staff retention problems, and system co-ordination issues, among others – all of which have been exacerbated since the start of the pandemic.

But the situation looks most stark for the criminal justice system, where anticipated progress on police performance would be reversed and dire performance in criminal courts and prisons would only worsen if the next government sticks to these spending plans.

The next government will face very difficult spending decisions – whoever is in office

A general election must happen by the end of January 2025 at the latest, with most expecting a spring or autumn 2024 vote. But whoever wins that election will inherit a delicate funding situation. If, as expected, that government does find it impossible to stick to current spending plans from 2025/26 onwards, then it will face difficult choices about how to raise the money.

The sums involved will be large. For example, if the government wished to increase total* or day-to-day departmental spending by as much as the 2007 spending review, this would cost an additional £34bn or £14.7bn respectively in 2027/28. This amounts to 1.4% of GDP for total spending, and 0.6% of GDP for day-to-day spending. Even a 1% real-terms annual day-to-day spending increase for non-health and aid services would cost £12.7bn. A £34bn increase in total departmental spending in 2027/28 is the equivalent of raising the basic rate of income tax by 5p, all rates of income tax by around 4p or VAT by around 4p.⁸⁶

In short, something would have to give: sustained higher spending on public services cannot be funded by short-term and relatively small measures such as utilising one-off underspending and increasing visa fees. If the next government wishes to raise such additional revenue then, without a major boost to economic growth, it will need to do so via key taxes.

Alternatively the government could seek to cut spending elsewhere or borrow more. However, it is hard to see where savings of this scale could be made and the next government may be reluctant to undertake additional borrowing to fund public service spending as there is currently little room relative to the fiscal rule to have debt falling as a share of GDP (which Labour has also committed to).

Performance improvement is possible but requires a big change in government's approach

Whoever forms the next government will face a daunting task just to return services to pre-pandemic levels of performance, never mind those seen in 2010. The problems described above are deeply entrenched and in some cases the result of decades of decisions. The next government should not expect to fix them over a single parliament. But the public should expect them to start the process. The longer that government takes to chart a better course, the harder it will be.

There is no meaningful fat to trim in public services – budgets have been under sustained pressure for more than a decade and there are no more easy cuts that can be made without damaging performance further. But services can run more efficiently, with higher activity and standards delivered on existing staffing and funding levels. Yet unlocking these productivity improvements will require a change in approach and, in some cases, upfront investment. That will not be simple, but the potential benefits are huge. For example, between 1997 and 2009, UK public sector quality

* Total is the sum of resource (day-to-day) spending and capital spending.

adjusted productivity increased by just over 5%.⁸⁷ Delivering a productivity increase of 5% across the services covered in this report now would be the equivalent of £11.8bn extra in funding.

The purpose of this report is not to set out an exhaustive range of solutions but to identify the key questions that any government serious about public service performance should be asking.

1. How can workforce disputes be avoided and experienced staff retained?

As discussed in detail above, the government's strikes strategy has likely extended the duration of pay disputes, and thus exacerbated the disruption caused to public services. And at least some industrial action is likely to continue. At the time of writing, junior doctors have committed to continued striking and consultants have said that they will undertake further industrial action if an improved offer is not made by early November.⁸⁸

Disagreements between government, unions and workforces over pay are inevitable, but it is in the interests of everyone that they are settled amicably. Pay review bodies (PRBs) are a helpful mechanism for doing so but this depends on all participants having confidence in the process. Unfortunately, government actions over the past year have politicised PRBs. Specifically, Rishi Sunak and his ministers have repeatedly emphasised the bodies' 'independence', using this to justify its refusal to reopen pay negotiations. However, PRBs are not *truly* independent: their remits are set by government; their recommendations can be rejected or partially rejected; and their recommendations are anchored by the government's evidence on affordability. While the government generally does accept the PRB recommendations and has done in recent years, including when the PRBs have recommended well above the affordability figure, the government's approach has led to a loss of confidence from unions in the PRB process.

Further, PRBs' recommendations are not an assessment of the optimum level pay needed to meet workforce demands, but are constrained by the funding that government says is available and the risk of rejection. It is right that PRBs consider affordability, but currently they are not usually explicit about how they have balanced this with other factors. To bolster confidence in the PRB process, the government should set PRBs' remits so that they are required to set out the impact that their recommendations will have on retention and recruitment. More transparently explaining the trade-offs would clarify that ultimately these are political decisions for ministers.

The government should also consider whether the Strikes (Minimum Service Levels) Act 2023 is conducive to productive long-term workforce relations. While this legislation should reduce the impact of each individual strike action, it could also result in strikes being prolonged, potentially leading to greater overall disruption to public services. It is also unclear whether it will give the government a stronger hand in negotiations or simply further erode its already damaged relationship with unions and staff.

Ultimately, the government cannot legislate itself out of a workforce crisis. If public sector staff do not think they are paid enough or if they are unable to strike, then they will withdraw their labour in other, often more permanent ways – moving to other sectors or taking early retirement. Many will opt not to join public service workforces in the first place. Given the impact that the loss of experienced staff has already had on the performance of public services, this would be a serious problem.

As part of a wider effort to retain high-performing, experienced staff, the government should reset its relationship with public service workforces and the unions that represent them. Pay will be a big component of this, but working conditions are also important. To that end the government should:⁸⁹

- Produce **workforce strategies** for all public services that set out plans to train and retain enough staff to meet the government’s objectives
- More regularly **consider the impact of its policy decisions** on staff workloads
- Improve **leadership and management**, including doing more to develop individual leaders, creating better organisational cultures, and ensuring there are enough managers in public services
- Support **flexible working initiatives**
- Develop a better understanding of the costs of poor **retention**, and the efficacy of different retention interventions.

2. How can the government set public services more stable long-term budgets?

In theory, the government sets high-level public service budgets for three-year periods through spending reviews, which set expenditure limits for their parent departments. While a case could be made for four- or five-year settlements covering the entirety of a parliament, three years probably achieves the right balance between providing services with certainty and the government with flexibility to change course in response to events.

In practice, however, recent governments have found it hard to maintain this rhythm. Uncertainty around Brexit led to a one-year spending ‘round’ in 2019, and the 2020 spending review, coming during the height of the pandemic, was also only for a year. A spending review is due in 2024, but this could be disrupted by a general election in the same year. Even if this makes it necessary to conduct a one-year review for 2025/26, the next government should commit to conducting a thorough three-year spending review for 2026/27 onwards so that it can effectively grapple with the huge problems facing public services.

Even where three-year spending reviews are undertaken, they have not always offered certainty to providers of front-line services. For example, spending reviews set the spending envelope for DLUHC, but local authorities themselves receive annual funding settlements, often announced less than three months before the start of the financial year.

Governments have also found it difficult to stick to spending review plans. For example, in the years after, and covered by, the 2015 spending review the government found it necessary to provide emergency funding for the NHS, criminal justice and social care as the amounts originally provided proved inadequate to ensure a politically acceptable level of performance.

While funding top-ups will sometimes be unavoidable in response to external shocks, short-term funding decisions have become business as usual. Bumpy, unpredictable funding allocations make it much harder for services to invest in improvements. Without greater certainty, providers are far less likely to consider productivity-enhancing changes to design and delivery due to the inevitable short-term disruptions and upfront costs incurred. Similarly, rather than investing in their permanent workforces, public services often have little choice but to use short-term funding pots on more expensive agency and temporary staff.⁹⁰

The next government must break this habit. Meaningful improvements could be made to the quality of public services by changing 'how' money is spent, without any changes to 'how much' is ultimately spent.

As a starting point, both the government – and opposition – need to be honest about how tight provisional spending plans for 2025/26 onwards are. As discussed above, given the current state of public services, it seems unlikely that whoever forms the next government will be able to stick to these plans; they will instead find it necessary to provide top-up funding in response to poor performance. Yet neither party has been willing to acknowledge this. This risks the election campaign being conducted on the basis of numbers that have little basis in political reality.

Difficult decisions will have to be made if the government is to break out of the damaging cycle of crisis-cash-repeat and it would be far better for the next government to have an electoral mandate for these. That should then be used by whoever forms the next government to set public service budgets at levels that are sustainable given current performance levels and likely future demand trends.

3. How can government ensure public services operate in a more stable policy framework?

Short-term policy making is as disruptive to the good running of public services as short-term funding. Rather than focusing on long-term service performance, public service leaders and front-line staff waste huge amounts of time and energy preparing for policy changes that never happen or are quickly superseded by further reforms. Such policy churn is endemic. Across the services covered by this report, there are high-profile recent examples of reforms that have been shelved or gutted due to loss of political support or cost savings.

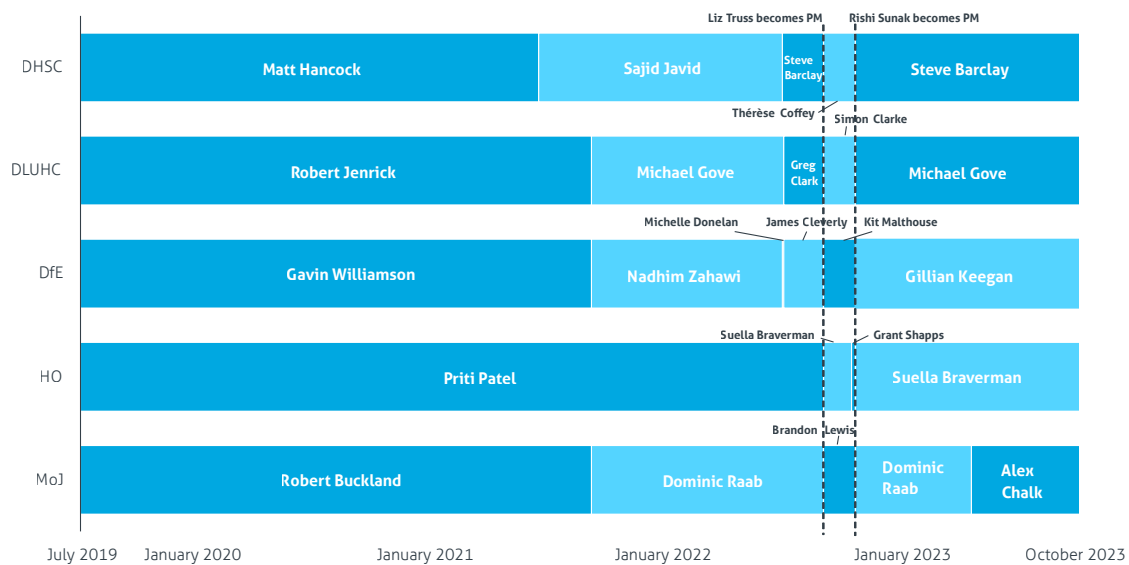
In the 2022 autumn statement the government announced that it was delaying the introduction of adult social care funding reforms for two years, giving up on its manifesto commitment to reform the service before the end of this parliament. In the NHS, the government put integrated care systems (ICSs) on a statutory footing in July 2022 but in March 2023 it told them they would need to cut their management

spending by 30% in 2023/24, precipitating the exit of some ICS leaders and disrupting their work. In schools, large parts of a high-profile schools white paper launched in March 2022, *Opportunity for All*,⁹¹ have subsequently been delayed or scrapped,⁹² including the Schools Bill, which passed most of the way through the House of Lords, before being dropped in December that year.⁹³

Policy should not be set in stone, and some changes are inevitable in response to real-world events, of which the pandemic is perhaps the best recent example. But long-term policy making has become the exception rather than the norm. The problem is structural, with both ministers and officials lacking incentives to take a long-term view due to the frequency with which they move roles.⁹⁴

The impact of ministerial churn can be seen in all of the examples given above. For example, there were five education secretaries between the schools white paper being launched and the Schools Bill being scrapped. Given the disruption caused by ministerial turnover, prime ministers should undertake fewer reshuffles and seek to retain ministers in post for longer. Similarly, permanent secretaries must be held accountable for reducing civil servant turnover.⁹⁵

Figure 0.13 **Secretaries of state in public service departments, 24 July 2019 to 30 October 2023**



Source: Institute for Government analysis of IfG ministers database, supported by CIPFA.

The Institute for Government has previously called for the civil service to be put on a new statutory footing, with an explicit 'stewardship' responsibility.⁹⁶ This would require it to maintain a long-term perspective on policy issues and ensure government has the capability to deliver. In this the UK should learn from New Zealand's Public Service Act 2020, which requires civil servants to consider the following for public services: "Long-term capability and its people; Institutional knowledge and information; Systems and processes; Assets; Legislation administered by agencies."⁹⁷

4. How can government provide public services with higher, more stable capital settlements?

Public service productivity has been harmed by limited and volatile capital spending. The UK spends very little compared to other rich nations, and that spending is highly volatile, centralised and often poorly thought through. As a result, teachers, doctors, nurses, prison officers, judges and other staff are often forced to work on outdated IT, without access to enough equipment and in crumbling buildings.

The next government will need to address these problems systematically if it wants to meaningfully improve the performance of public services. Most importantly, it will need to consider how to boost capital budgets. As discussed above, the UK is an international laggard when it comes to capital spending, having consistently invested less as a percentage of GDP than the OECD average since at least 1960. It is clear that sustained higher capital spending will be required to get the most out public service staff, but this will undoubtedly be difficult given the state of UK public sector finances.

In the short term, boosting capital budgets may require higher overall spending. But the government should consider how the balance of funding provided to different services can be shifted over the medium to long term so that the proportion accounted for by revenue falls, with more being spent on capital instead. This could, for example, be incentivised through changes to the fiscal objectives set by government.⁹⁸

Capital spending is also volatile, with six times as much variation in investment growth as there is in day-to-day spending.⁹⁹ This makes it much harder for public sector bodies to commit resources to long-term projects and for supply chains to be built up. In turn, this contributes to consistent underspending of capital allocations.¹⁰⁰ In addition, recent governments have raided capital budgets to cover shortfalls in day-to-day spending. Planning capital projects only to see the money reallocated to day-to-day spending or in-year underspends returned to the Treasury means incurring costs and wasting scarce management capacity for no reason.

Government must think about how it can make capital budgets more predictable and protect allocations that have already been made. Setting more sustainable budgets, as recommended above, would reduce the risk of capital allocations being raided, but more could be done to provide certainty to services.

It is also critical that spending – whether on maintenance, new buildings, equipment, IT or other forms of capital – is allocated to those projects most likely to improve public service productivity and performance. This will differ between services and areas, depending on the workforce mix, demand and other factors. The government should therefore ensure that it is properly monitoring and evaluating capital projects, and disseminating the findings across the public sector. This could also be achieved partly through greater devolution of capital spending responsibilities. Currently this is highly centralised, with front-line services often requiring departmental or Treasury sign-off for relatively small projects.

Finally, a government planning a meaningful increase in capital spending would need to think carefully about the sequencing of investments and the capacity of the private sector to deliver within a given timeframe. For example, running major hospital and school building programmes simultaneously could drive up costs as different parts of the public sector compete with each other for the services of suitable providers in the construction industry – where there are currently skills shortages necessitating the visa rules for foreign construction workers. This oversight might best be undertaken by the Infrastructure and Projects Authority as part of its responsibility for the National Infrastructure Construction Pipeline.

5. How can government focus more on public service outcomes ?

Government is too often focused on inputs and outputs, rather than the real-world impact that public services can have. For example, the headline public service commitments in the 2019 Conservative manifesto were 50,000 more nurses and 50 million more GP surgery appointments a year, 20,000 more police, and millions more invested every week in schools.¹⁰¹ This translates into governing where too little consideration is given to how best to allocate funding between and within services to improve people's lives.

In recent years, the government has taken a more outcome-focused approach to public spending, through the introduction of outcome delivery plans (ODPs). Initially set at the 2020 spending review and then updated at the 2021 spending review, these include high-level priority outcomes for each department, plans for achieving these and performance measures. ODPs have been updated internally for 2023/24 but departments have been prevented from publishing these. While far from perfect, ODPs are a step forward, recognising the complex and cross-cutting nature of most policy problems, and having the potential to contribute to government efficiency. The government should allow departments to publish their ODPs to retain buy-in to the process.

Incoming governments have a habit of scrapping the performance framework of their predecessor. The next government should avoid this temptation and build on ODPs. Previous Institute for Government work has recommended that they could be enhanced through better co-ordination between departments of cross-cutting outcomes, greater input from the front line, experts and people with lived experience, more relevant targets and metrics, improved transparency, and better linking of budgets to outcomes.¹⁰²

More broadly, CIPFA has previously published a guide¹⁰³ and toolkit,¹⁰⁴ which set out how public sector managers can better consider outcomes in public services.

6. How can government ensure the right balance between fundings of acute and preventative services?

Since at least 2010, statutory funding for some public services has increasingly focused on acute services at the expense of preventative ones. Local authority spending on children's centres and youth services has been cut by more than half since 2010, while that on safeguarding and providing care to children in care has risen dramatically. Similarly, spending on hospitals has continued to grow, at the same time as public health budgets have been cut.

The current balance between resourcing of acute and preventative services is suboptimal and the government should consider how this can be improved. As a first step, it should better evaluate the impact of preventative investments¹⁰⁵ as the current approach is not an effective way to spend public money. By failing to offer support before problems escalate, the state instead has to make more expensive interventions at a later date.

The government should also think about the mechanisms for shifting funding towards prevention. This might include changes to budgeting processes, accounting, incentives and cross-organisational working. As with the need for a greater proportion of spending to be on capital investment, a new government could decide on the need for upfront investment in the short term to reverse past decisions, followed by a rebalancing of spending in the medium to long term.

Given the potentially long timeframes for realising the benefits of a greater focus on prevention, the government should also consider what it can do to create greater consistency in approach to preventative spending across parliaments.

One potential route to a greater focus on prevention is further devolution of public service budgets to regional or local levels, allowing the creation of shared budgets between services for particular areas. This could help improve incentives to spend on preventative services as savings often accrue to a different part of the public sector. For example, local authority spending on Sure Start children's centres has been shown to have created savings for the NHS by reducing the number of childhood hospitalisations.¹⁰⁶ Indeed, research has found that life expectancy in Greater Manchester performed better than expected following devolution, with improvements "likely to be due to a co-ordinated devolution across sectors, affecting wider determinants of health and the organisation of care services".¹⁰⁷

The Better Care Fund is another example of a policy that, among other objectives, uses shared budgets to incentivise preventative spending. An evaluation of the programme found that prevention activities were a popular use of BCF funding and that these helped to reduce the number of people who were delayed in leaving hospital due to problems in the NHS.¹⁰⁸

Short of greater use of shared budgets between service providers, central government should give councils more control over the funding they already receive. Both the Institute for Government and CIPFA have previously highlighted that local government in the UK is unusually reliant on ring-fenced central government grants, which require compiling bids and competing with other areas to access the funding. Aside from the time and expense wasted in bidding, this approach makes it much harder for councils to focus on long-term impact and tailor investments to the needs of their area.^{109,110}

The rest of this report looks at each of the services covered in detail.

1. General practice



General practice: key figures

- **1,910** – Fewer fully qualified, permanent GPs in general practice in September 2023 compared to September 2015 – a 6.7% decline
- **10.5%** – The proportion of the under-40 GP workforce that left the service in the 12 months to March 2023 – a record high
- **162.3m** – Appointments delivered by GPs in 2022/23 – a 5.3% increase on 2019/20
- **12.5m** – Referrals made by GPs in 2022/23 – a 4.5% increase from 2021/22, but still below the 13.2m made in 2019/20
- **31,370** – More direct patient-care staff in June 2023 than in March 2019 – exceeding the government’s target of 26,000

Introduction

General practice is delivering more appointments than ever. This is partly because of the government’s successful recruitment of more than 30,000 additional direct-patient care staff – fulfilling a manifesto commitment – but also because GPs themselves are providing more appointments, even as the number of fully qualified, permanent GPs continues to fall. This is in contrast to secondary care, chiefly hospitals, where the post-pandemic puzzle has been why more staff are delivering less activity on some measures than in 2019/20.¹

Despite this record activity there is still not enough capacity to meet demand, with patients struggling to access appointments. In response, the government published its *Delivery plan for recovering access to primary care* in May 2023.² It is still too early to tell if that plan will have the desired effect, but it at least recognises some of general practice’s problems, such as historic underinvestment in capital: it contains a proposal to upgrade practices’ telephony systems.

The government is not taking a similar approach to all elements of general practice funding. It has remained wedded to funding levels agreed in 2019, despite recent inflation being far higher than predictions at the time, and has ruled that the recent uplift in GPs’ salaries must be paid for by reallocating funding from elsewhere in the NHS.³ The BMA’s General Practitioners Committee (GPC) threatened to ballot on industrial relations in response, but has since backed down in anticipation of a new contract in 2024/25.

As elsewhere in public services, high workloads are adding to the stress of the job for GPs and are likely contributing to growing numbers leaving general practice. Retention issues are particularly acute among younger GPs, with record numbers of GPs aged under 40 leaving general practice in the 12 months to March 2023 – there are now fewer GPs in this age group than at any other time on record. And while the NHS has recruited record numbers of GP trainees, not all stay in general practice after receiving their qualifications. Resolving the crisis in the GP workforce should remain the government's top priority for general practice.

Spending and funding

Spending on general practice increased in 2021/22

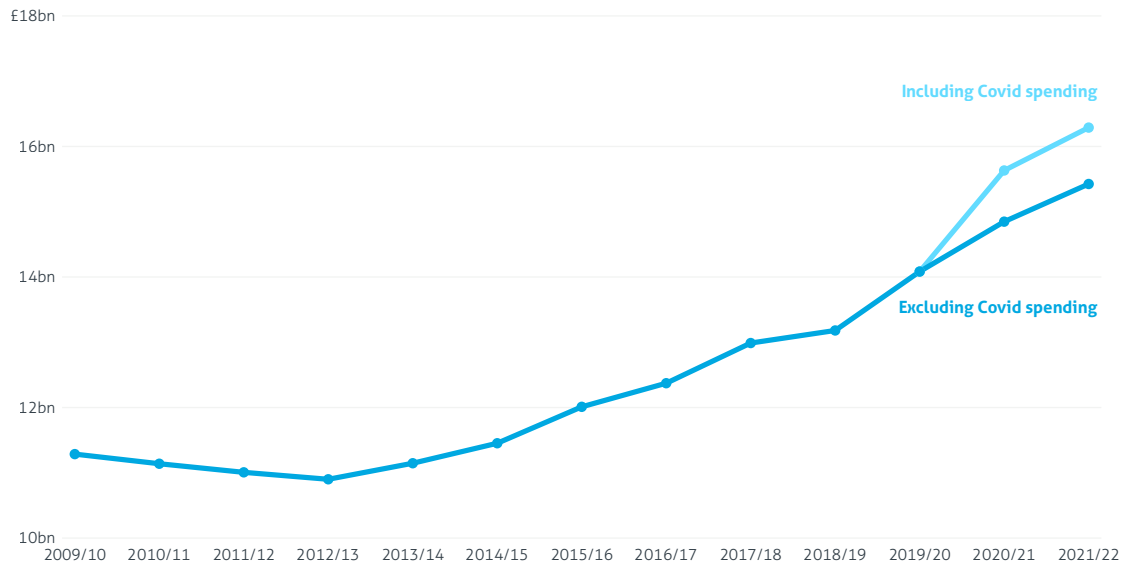
Including Covid measures, spending on general practice rose by 4.2% in real terms in 2021/22, bringing the cash total to just over £15bn. Covid accounted for just under £800m (5.3%) of that total, and grew by 10.2% in real terms in 2021/22. This extra spending was primarily driven by increased spending on the vaccine programme, which rose from £333.9m in 2020/21 to £727.0m in 2021/22 – an increase of 112.1%.

Excluding this spending, the NHS increased its spending on general practice by 3.9% in real terms in 2021/22. But growth in spending was not distributed equally across all parts of general practice.

Spending on primary care networks (PCNs, organisations that the NHS launched in 2019 as part of the NHS Long Term Plan, designed to improve cooperation between practices and other parts of the health and care system)⁴ grew more quickly than any other area of spending in 2021/22. The budget for PCNs grew from £568.4m in 2020/21 to £1.0bn in 2021/22 – an increase of 74.3% in real terms. Excluding Covid spending, the proportion of investment in general practice spent on PCNs has risen from 2.0% in 2019/20 (the first year PCNs existed) to 7.1% in 2021/22.

Excluding PCNs and Covid gives a better picture of the funding available for core general practice services, and shows that the NHS increased spending on GP services by just 0.4% in real terms in 2021/22.

Figure 1.1 Spending on general practice, 2009/10–2021/22 (2023/24 prices)



Source: Institute for Government analysis of NHS Digital, 'Investment in General Practice, 2009/10 to 2013/14', NHS Digital Investment in General Practice, 2011/12 to 2015/16 and NHS England, 'Investment in General Practice, 2017/18 to 2021/22' ('Table 3a'), supported by CIPFA. Notes: Figures cover both current and capital spending. These figures include the reimbursement of drugs.

The 2023/24 GP contract does not increase funding in line with inflation

The relationship between general practice, NHS England and the government is different from other parts of the health system. Practices effectively operate as small, independent businesses that the NHS contracts to provide services.⁵ The NHS reimburses practices for the services they deliver largely depending on the size and composition of their patient lists, with, for example, older patients and patients with higher needs attracting more funding. The 2023/24 financial year is the last of the current five-year GP contract that started in 2019/20 and which was negotiated by NHS England and the British Medical Association (BMA, the union that represents doctors) in 2018 and early 2019.⁶

When a contract is agreed, GP partners – who own and manage GP practices – take on a certain amount of personal liability to deliver those services. The expense of running a practice comes out of the income practices receive from the GP contract, and GP partners pay themselves after other expenses (the largest part of which is other practice staff's salaries)⁷ have been met.

Over the last two years, the BMA's GPC and NHS England have disagreed about the level of funding that the current GP contract provides. The BMA thinks that NHS England (NHSE) should have provided an uplift to help alleviate "pressures being faced by GPs and their teams"⁸ that have arisen from inflation. For its part, NHSE and the government think that general practice should see out the contract that they previously agreed. As it stands, NHSE has gone ahead with the previously agreed contract in both 2022/23 and 2023/24, which the BMA has labelled an "imposition of an 'insulting' and 'inadequate' contract".⁹

There is some merit to the government's argument. As independent contractors, GPs should be expected to take on risk when they agree to a new contract. There are, however, arguments against this decision, and 2023 is clearly different from 2019. First, general practice worked through a global pandemic. That led, in some instances, to the government imposing new requirements on general practice without providing sufficient additional funding. For example, in September 2022, the government announced that GPs would have to provide appointments to patients within two weeks of them first requesting one.¹⁰ There has also been a shift towards more remote appointments, and a general rise in costs. Some of these changes are funded – for example, the government will provide £240m of funding to shift practices to a cloud-based telephony system¹¹ – but many are not.

Second, there has been a bout of above-forecast inflation which has driven up the cost of providing GP services. Despite that, the government chose largely to stick to the cash funding levels agreed in 2019.¹² This means that the contract baseline increased by only 2.5% in 2022/23 and will increase by 2.7% in 2023/24,¹³ despite economywide inflation (as measured by the GDP deflator) increasing by 6.6%¹⁴ in 2022/23 and being forecast to increase by 2.5% in 2023/24.¹⁵ At the time that the contract was agreed, the GDP deflator was not forecast to rise above 2% in any year of the contract,¹⁶ meaning that the contract baseline would have increased by 2.1% in real terms by 2023/24, compared to 2018/19.

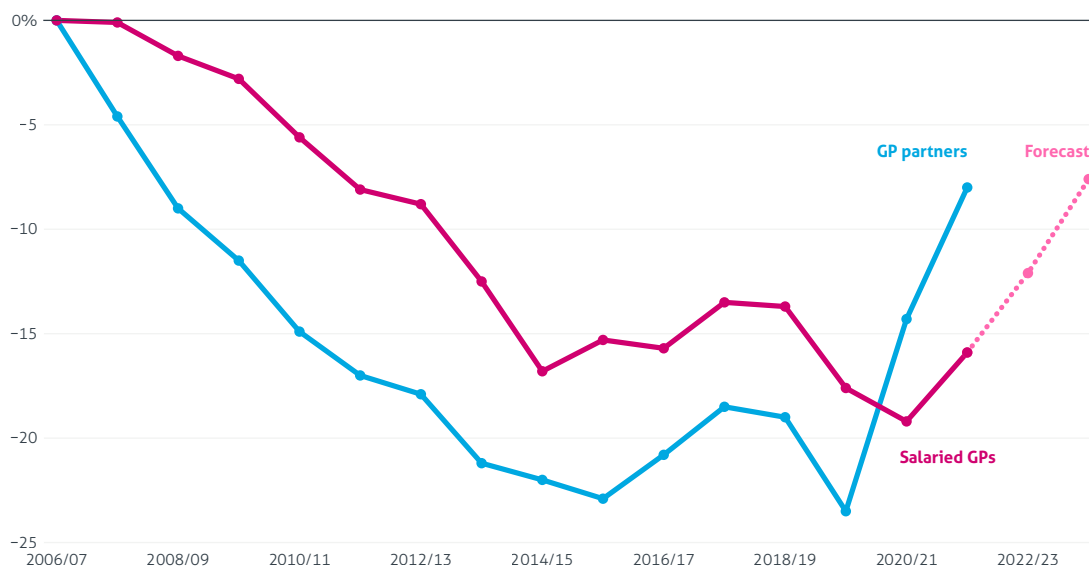
Instead, the contract baseline is now forecast to be 5.1% lower in real terms than in 2018/19. In addition, wages, a major cost to practices, are likely to rise faster than inflation in 2023/24. The government has agreed to fund the increase in salaried GPs' pay, but any increases for other practice staff will need to come out of existing budgets. This will in turn mean less funding available for other parts of general practice – but will be hard to avoid given the risk of staff leaving for better pay in, for example, secondary care.

The government's line that GPs should honour the contract they agreed to in 2019 is short-sighted. Maintaining such a hard line in the face of obvious budgetary pressures risks worsening the problem of retention in general practice and losing more of the workforce. That will make it much harder for the government to provide a politically acceptable standard of primary care.

Recent pay increases still leave GPs worse off than in 2006/07

There has been a long-term trend of declining pay for both GP partners and salaried GPs.* On the eve of the pandemic, GP partner pay was already some 23.5% lower in real terms than 2006/07, and salaried GPs' pay was 17.6% lower.

Figure 1.2 Change in GP pay, since 2006/07 (real terms)



Source: Institute for Government analysis of NHS Digital, 'GP earnings and expenses estimates' 2021/22 ('1a. Contractor earn. by country' and '7a. Salaried by country' tables), supported by CIPFA. Notes: It is not possible to project GP partner pay as there are no recommendations for the amount that they will draw as salary. This chart uses CPI to put GP salaries into real terms. Forecast is based on announced pay deals.

Since then there has been an increase for both staff groups. GP partner pay increased by 12.0% in real terms between 2019/20 and 2020/21, and by a further 7.4% in 2021/22. In the first year of the pandemic, this was mostly due to Covid support money, increased income from the Covid vaccine programme (some of which continued into 2021/22 and a reduction in costs, such as locum expenses during the first lockdown. Despite those large recent pay increases, GP partner pay was still 8% lower in real terms in 2021/22 than in 2006/07. This is likely to make GP partnership less attractive at a time when the number of GP partners is already falling – a trend that could lead to more practice closures, as explored in more depth below.

Pay for salaried GPs has also risen since the onset of the pandemic, by 2.0% in real terms between 2019/20 and 2021/22.** The agreed pay deals in 2022/23 and 2023/24 will further increase pay in real terms, but will still leave it 7.6% lower in real terms than in 2006/07. Other than in 2023/24, when part of the uplift for salaried GPs was funded, GP practices have had to pay for recent pay uplifts out of the GP contract.

* GP partners are essentially self-employed contractors who operate a GP practice. They take their pay from what is left over after a practice has incurred its operating expenses. Salaried GPs are employees who work for a practice and take a salary that is agreed in advance between them and the practice. GPs cannot be both salaried and partners.

** We were warned that the trend of salaried GPs increasingly working part-time may have artificially pushed this time series downwards, as each year shows the average salary reported to HMRC by an individual GP. Despite that, we felt that the trend is substantial enough that there would have been a fall in pay, even if GPs had maintained the same number of hours.

The forecast increase in 2023/24 for salaried GPs comes following a government decision to increase their pay by 6% in that year,¹⁷ after initially recommending a 2.1% pay increase.¹⁸ Importantly, the GP contract will be uplifted to account for this higher pay settlement, though it does not seem that this is additional funding for the NHS from the government, but rather money that is being reallocated from other parts of general practice.¹⁹

The prospects for other practice staff are not so positive. The GP contract allows for a 2.1% pay rise for other practice staff in 2022/23 and 2023/24²⁰ – however, this is against private sector wages increasing by around 7% in 2022²¹ and a forecast 5.5% in 2023.²² More comparable, though, are the increases that the government has given to non-medical staff who work in hospitals. Those staff have received pay increases of 4.7% in 2022/23 and will receive a 5.2% increase on average in 2023/24, in addition to one-off payments worth 6% of their salary in 2022/23.²³ In short, pay increases in general practice are not competitive with either the wider economy or other parts of the NHS, posing a risk to staff retention. This means that funding for general practice is not sufficient to provide all staff with competitive pay increases without imposing cuts on other areas of primary care.

Dissatisfaction with the GP contract has led the BMA to threaten balloting GPs on industrial action,²⁴ though it has since backed down from that position in anticipation of a new contract in 2024/25.²⁵ Still, the possibility of industrial action hangs over general practice, especially as colleagues in other NHS services continue to take to the picket lines. A likely general election in 2024 adds further complications to negotiations. GP leaders will want to agree a contract with a new government, with reports that this could mean that they will push for a one-year holding contract to bridge the gap between 2023/24 and 2025/26, when the longer-term contract would start.²⁶

GPs often work in cramped and poorly maintained premises with outdated IT

It is more difficult to assess the sufficiency of capital spending in general practice than in other services, as there is little publicly available data to show the quality of the estate, IT systems or equipment.²⁷ Much of the estate is not owned by the NHS itself: the May 2022 Fuller Stocktake reported that only 14% of premises are owned by NHS Property Services, with the rest owned by GPs themselves and third parties.²⁸

Despite the difficulties in accessing good data, the indications from information that is publicly available and our own interviews are that capital investment in general practice has been insufficient to ensure the primary care estate meets the requirements of a modern health service.

A survey of clinicians shows that one in four GPs are treating patients in premises that are not fit for purpose.²⁹ Lack of space seems to be a particular issue: 88% of GPs say that there are not enough consulting rooms,³⁰ 66% say that the lack of space makes it harder to train new GPs,³¹ and 84% report that estate space restricts how many GP trainees they can take on.³² One GP responding to a Royal College of

General Practitioners (RCGP) survey said: “Lack of space is our biggest constraint. There is no funding to address accommodating physios, mental health, and social care practitioners, [this] has led to GPs working in cupboards – it’s hopeless”.³³

The lack of capital investment is not, however, limited to the estate. IT systems in general practice are often out of date. Almost half (46%) of respondents to the RCGP’s survey say that PC or laptop software is not fit for purpose³⁴ and more than a third of general practice staff say that their broadband is not of an acceptable standard.³⁵ It is not just the quality of IT within practices that prevents more efficient working – close to two-thirds (65%) of staff say that their ability to exchange information with the wider health service is not fit for purpose, driven by underinvestment in software that makes it easier to share information.³⁶

The reasons for this are complex. The NHS argues that responsibility for capital investment in primary care lies with GPs, given their status as independent contractors. As such, GPs should provide and maintain an appropriate estate and ensure that IT systems are fit for purpose. While this is technically true, the reality is more nuanced. GPs are not well suited – either financially or from a logistical perspective – to make the required level of capital investment in general practice.

On financing, the GP contract is a poor mechanism for allocating capital investment. First, unlike how funding is allocated to government departments, there is no ring-fencing for capital investment in the amount provided to GPs, meaning that capital directly competes with other funding pressures, such as a requirement to increase practice staff wages. The result is that, as a government review of general practice premises policy found, there is “a lack of clarity or understanding around the responsibilities of all parties involved in estate ownership and occupancy” which can mean that property is not maintained to the level it should be.³⁷ It could be argued that GP partners – as the holders of GP contracts – should reduce their earnings to fund investment. But on an individual practice scale, that may not generate enough cash for the type of investment required* and would likely further harm GP partner recruitment and retention at a time of declining numbers, as discussed below.

GPs are also somewhat at the mercy of national policy making. For example, the problem of limited and inappropriate estate space has been compounded by the expansion of multi-disciplinary teams (MDTs), which includes the addition of 29,103 direct patient care (DPC) staff (discussed more below). But that policy has not been accompanied by concomitant intention or funding to expand the estate, with de facto responsibility falling to practices to accommodate them.³⁸ This means that the government is not using those new staff as effectively as they might otherwise be, eroding value for money.

* There are on average 2.6 GP partners in each GP practice, with each earning £117,320 per year on average in the last decade. If they reduced their drawings by 10% – a substantial amount that would likely harm partner recruitment and retention – it would only raise £30,503 per practice per year. Totalled across all general practice, this would represent just under 1.4% of the amount that the NHS spent on general practice in 2021/22.

The Fuller stocktake asserts that when it comes to utilising multi-disciplinary teams, the primary care estate is “not up to scratch”³⁹ and that the NHS needs to develop “hubs within each neighbourhood and place to co-locate integrated neighbourhood teams... for the provision of more integrated services”.⁴⁰ As an example of the kind of investment needed, it uses the case study of a health centre that was developed in Waltham Forest through a partnership between the local authority and the local NHS, at a cost of £1.4m.⁴¹ That scale of investment and coordination of stakeholders is far beyond the ability of any practice – or even small group of practices – to deliver, either financially or logistically.

The same argument holds for investment in IT. Practices are responsible for providing hardware for their employees, and often (as noted) fail to provide an adequate standard. But it is beyond their ability to provide systems that, for example, enable data sharing between different parts of the NHS – an outcome that requires large-scale investment and coordination. Even when individual practices can purchase their own IT systems, this is unlikely to represent good value for money; the Fuller stocktake again argues that, when procuring IT systems, integrated care systems could “leverage their larger scale and purchasing power to improve value for money and quality of service”.⁴²

The government has recognised this and taken some steps to address the issue. On estates, it has proposed investing in six “Cavell centres”, intended to provide appropriate space for the integration of primary, community and social care services. But the *Health Services Journal* reported in March 2023 that NHSE had ordered that work on the centres be stopped until a national business case had been approved.⁴³

On IT systems, the government used the *Delivery Plan for Recovery Access to Primary Care* to allocate £240m over 2023/24 and 2025/25 “for new technologies and support offers for primary care networks”,⁴⁴ which includes some portion going to improved cloud telephony for practices. This is welcome, but is targeted at a very narrow, patient-facing part of the service and will not address many of the IT issues laid out above. It also comes at the expense of spending elsewhere in the health and care sector, as the government chose to “retarget” funding rather than make new money available.⁴⁵

One interviewee suggested that decision making for capital investment in primary care could be improved if it was shifted upwards from GP partnerships to integrated care boards (ICBs), who would be best placed to make decisions about how to coordinate care between community care, primary care, mental health and adult social care providers. This would also allow ICBs to leverage their size to achieve better value for money.

Demand

General practice does not have enough capacity to meet demand

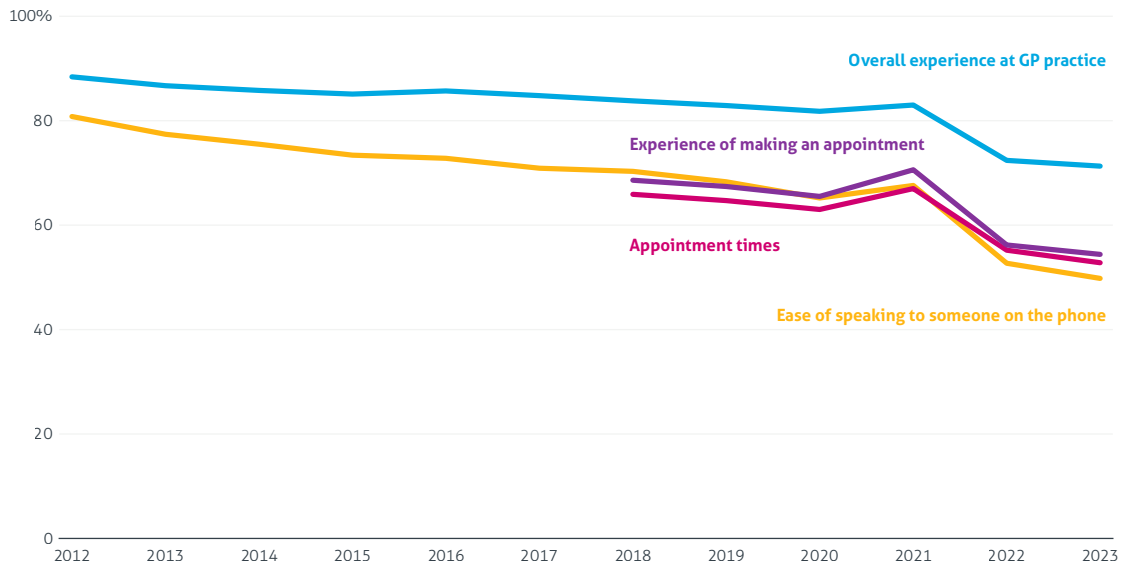
Anecdotally, demand for GP services has never been higher. The so-called “8 am rush” for GP appointments has featured prominently in the press over the last year.^{46,47} Supporting the anecdotal evidence with data is harder. It is possible to observe the number of appointments that general practice delivers: this increased by 12.4% between 2019/20 and 2022/23, an average of 4.0% per year. But that amount is necessarily limited by general practice capacity. There is therefore an unobservable number of people who try and fail to book an appointment on any given day (though there is evidence that people are finding it harder to book appointments, more on which below).

Demographic changes appear to have increased demand on general practice. While the overall population in England grew by 0.6% per year on average between April 2013 and April 2023, the over-65 population grew at 1.1% per year – the same proportion as rise seen in the number of patients registered with GPs.⁴⁸

That older population often has more complex needs – and the proportion of people aged 75 and over with two or more long-term conditions is also increasing.⁴⁹ We heard throughout our interviews that patients are presenting with more complex conditions and therefore higher need for care across all health and social care services. This has again proved difficult to evidence, but if true would imply that it is not only the quantity of demand that has changed, but also the complexity.

Respondents to the GP Patients Survey also show decreasing satisfaction on questions related to access.⁵⁰ For example, the proportion of people who are satisfied with the experience of making an appointment and who found it easy to talk to someone on the phone dropped to 54.4% and 49.8% respectively in 2023, both the lowest scores on record. This has fed through to the lowest patient satisfaction on record with 71.3% reporting a positive experience of general practice in 2023, down from 82.9% in 2019. It could be argued that these results show a general frustration with the service. But polling shows that those who access general practice are more satisfied with the service than those who do not.⁵¹ These results imply that people are struggling to access general practice when they need to.

Figure 1.3 Patient satisfaction with general practice, 2012–2023



Source: Institute for Government analysis of NHS, GP Patient Survey 2023, supported by CIPFA. Notes: This chart shows responses to questions 1, 6, 21 and 32 in the survey. The numbers shown in the chart indicate what proportion of respondents gave the two most positive responses. For example, for the overall experience question, this shows those who responded “Fairly good” or “Very good”. Each time series starts from the first year the question was asked.

The proportion of people who had contact with general practice also declined in 2022, from 86% in 2021 to 84%.⁵² This could be because of falling demand, but could also be because well-publicised difficulties accessing general practice meant that people chose to stay away with conditions that they might previously have come forward for.⁵³ This doesn’t necessarily imply that GP workloads have fallen, however; a patient with increasingly high needs would demand more from general practice.

There are other reasons why demand could in fact be rising in general practice. The phenomenon of “workload dumping” from secondary care into primary care – the inappropriate transfer of work from hospitals to GPs – has been recognised for a while as a driver in demand for GP services,⁵⁴ though it is difficult to know if this has worsened in recent years.

All of these measures of demand are incomplete and it is difficult to unpick how much of the demand from the past few years was part of a pandemic backlog that may now largely have been cleared. Either way, it is clear that there is more demand for GP services than general practice can meet.

The government is attempting to manage demand out of the system

The government has recognised that demand pressures are a problem. It used NHS England's *Delivery Plan for Recovery Access to Primary Care*⁵⁵ to implement various measures to improve access to GP services, which can involve directing patients to where they might be able to access more appropriate care. These include:

- improved patient self-referral to hospital care
- self-treatment
- use of other practice staff to meet demand
- rollout of “care navigation” to better advise and signpost patients to the right service or health professional

The *Delivery Plan* claims that practice teams spend 10–20% of their time on “lower-value administrative work and work generated by issues at the primary-secondary care interface”.⁵⁶ The NHS plans to alleviate some of that pressure using measures such as encouraging secondary care colleagues to make onward referrals within secondary care, rather than returning the patient to primary care for the referral to be made.⁵⁷

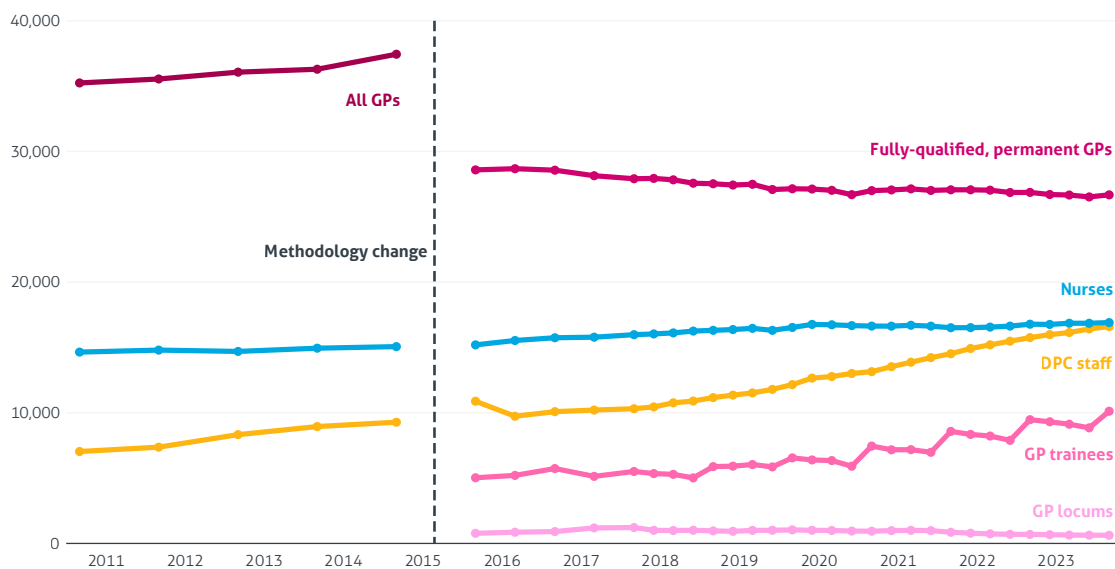
It is still too soon, however, to assess if these will be effective. The NHS frames these interventions as signposting patients to a more appropriate service, thereby reducing demand for general practice. This could work – as long as there is sufficient capacity in those other services. It could be more appropriate, for example, for a patient to receive care from community health services. But there is evidence that capacity in community health has declined,⁵⁸ with a 34.1% and 30.3% decline in the number of district nurses and health visitors respectively between September 2010 and June 2022.⁵⁹

Workforce

The number of fully qualified permanent GPs continues to fall

Continuing a long-running trend, the number of fully qualified, permanent GPs continue to fall in 2023/24, with 188 fewer in September 2023 than in the same month the year before – a 0.7% decline. This means the number is 6.7% (1,910 total GPs) lower in September 2023 than in September 2015.

Figure 1.4 **General practice primary care workforce by role (FTE), September 2010 to September 2023**

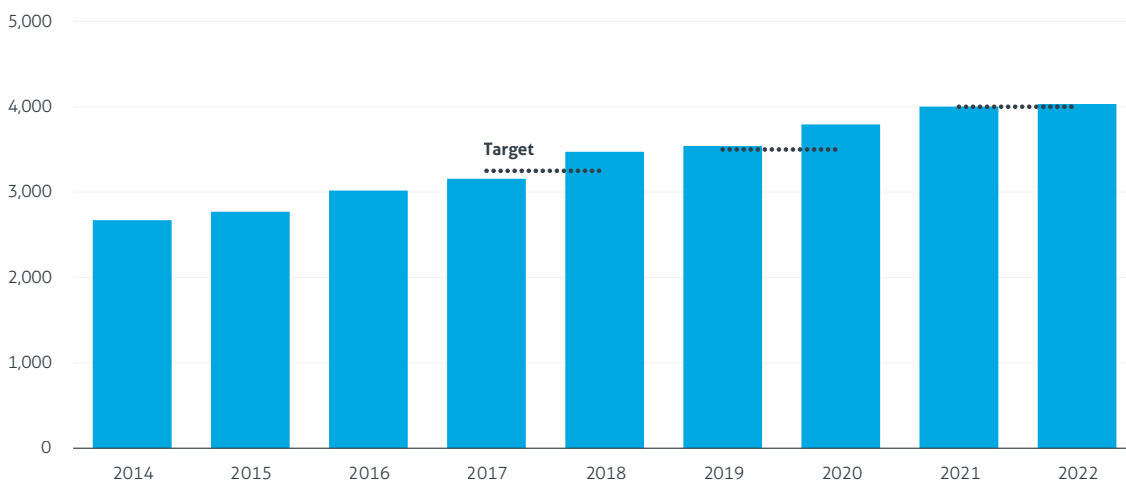


Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – September 2023' (table '1a') and NHS Digital, 'General and Personal Medical Services, England, 2004–14, as at 30 September', supported by CIPFA. Note: The number of direct patient care (DPC) staff in this chart is not directly comparable with other charts in this chapter. This is because the former includes only those DPC staff who work in GP practices, while the latter includes DPC staff employed across wider primary care networks.

The NHS recruited a record number of GP trainees in 2022

While the number of fully qualified, permanent GPs has declined, the NHS recruited a record 4,032 GP trainees in 2022 – the fifth year in a row that it has exceeded its recruitment target – the most recent year for which there is currently comparable data. The NHS has plans to further increase the number of GP trainees, with an ambition to have 6,000 trainees by 2031 – a 50% increase in the current number of training places.

Figure 1.5 **Recruited GP trainees, compared to target, 2014–2022**



Source: Institute for Government analysis of Health Education England, GP trainee recruitment data, 2022, supported by CIPFA.

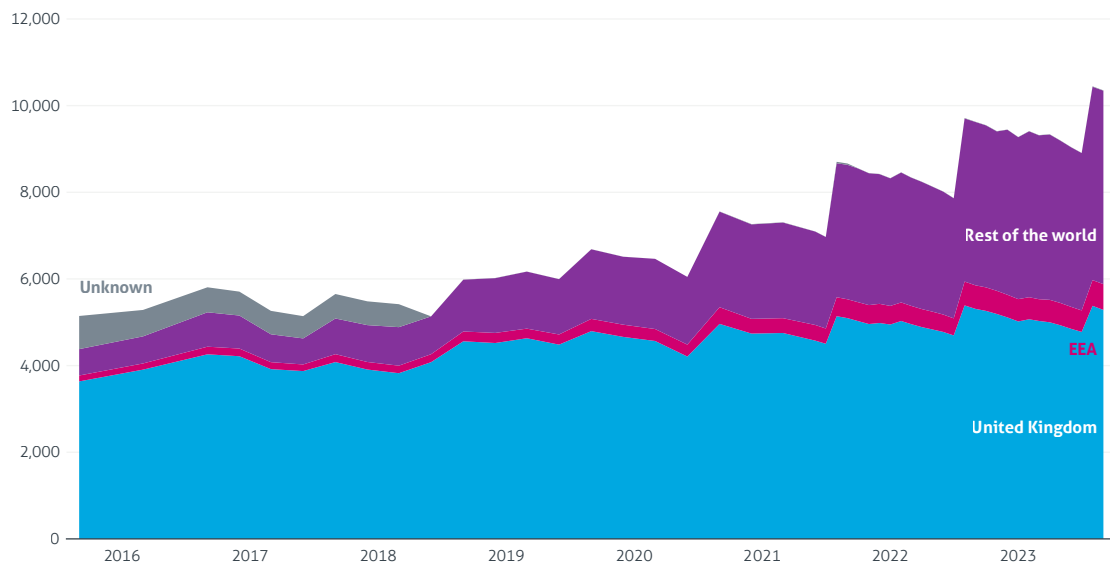
However, these record numbers of trainees are not translating into an increase in full time-equivalent (FTE) GPs. This is for a few reasons. Interviewees claimed that the realities of working as a GP often put trainees off continuing with the specialty. Many of the same factors that lead more experienced GPs to leave the service also act as push factors for trainee (and newly qualified) GPs. In particular, high workloads, long hours and stressful working conditions mean that many trainees look elsewhere for work when they qualify, and often move specialties; some choose to work abroad.⁶⁰

While it is good that the NHS is managing to recruit more GP trainees than ever, it is not without cost. Training is undertaken by senior colleagues, known as GP trainers, who supervise trainees until they are confident that they are competent enough to work alone.⁶¹ More trainees means more training. That increases the workload of other GPs. At a time when GPs are already leaving general practice due to poor work-life balance, this risks further worsening the retention problem.

The NHS is increasingly relying on international recruitment to fill trainee roles

It is not just the number of GP trainees that has changed in recent years, but also the source of GP trainees. There were 5,208 more GP trainees in September 2023 than in September 2015. But the increase has been predominantly driven by recruitment from abroad, with 3,856 more trainees from outside the UK and the European Economic Area – a 633.2% increase in that time. In contrast, the number of UK trainees increased by only 45.4% (or 1,650) over the same period. Trainees from the rest of the world made up 43.1% of the total number in September 2023 compared to 17.0% in June 2018, before the recent recruitment drive.

Figure 1.6 **GP trainee headcount, by country of qualification, September 2015 to September 2023**



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – September 2023' (table '4'), supported by CIPFA.

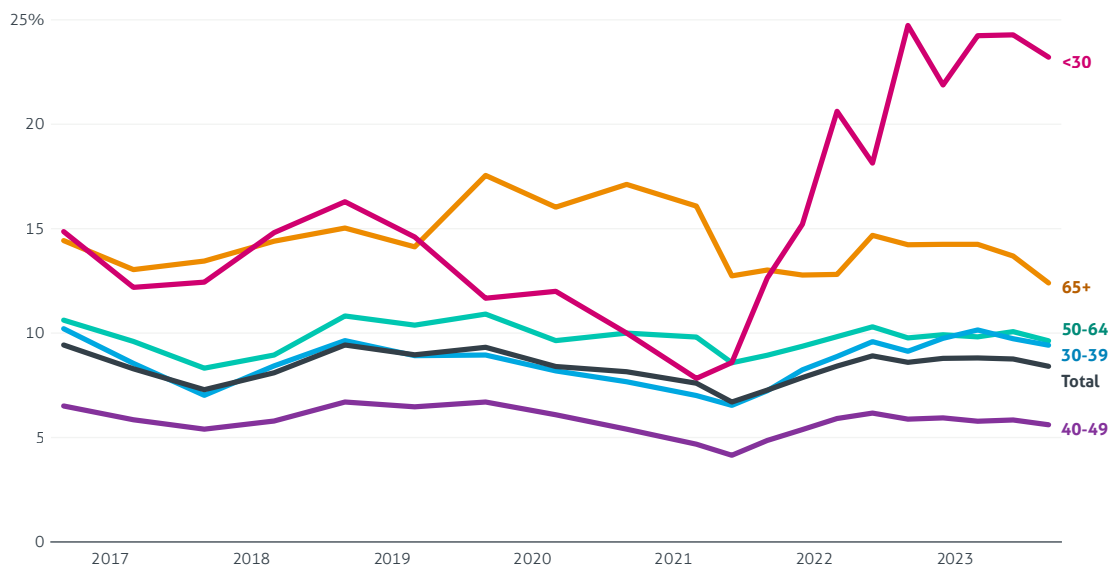
This increasing reliance on international medical graduates (IMGs) to fill GP training spots raises questions of sustainability, ethics and value for money. On sustainability, the UK faces increasing competition from the rest of the world for a limited pool of medical graduates. Recruiting doctors away from other, often more deprived, countries falls into an ethical grey area.

On value for money, the Royal College of General Practitioners (RCGP) estimates that it costs the NHS £50,000 per trainee per year, regardless of country of origin.⁶² But work from the General Medical Council (GMC) shows that IMGs are more likely to leave the NHS sooner than UK trainees. Some 89% of UK graduates who registered with the GMC in 2015 were still licensed in 2021, compared to 66% of IMGs.⁶³ This implies that the government is getting less for the money it invests in IMGs than British graduates.

Younger GPs are leaving general practice at record rates

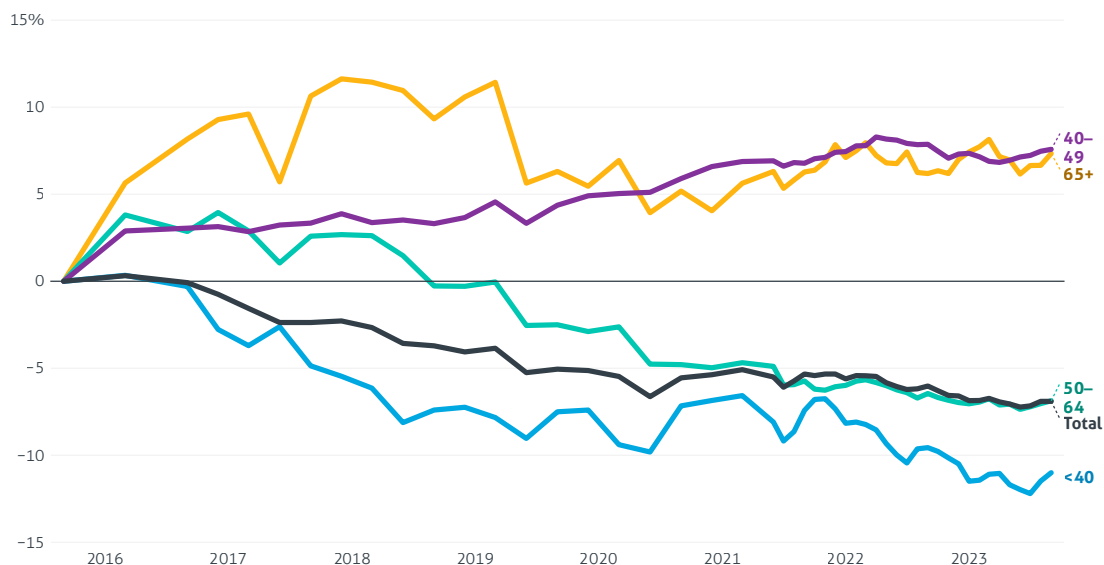
As with other public services, there was a drop in people leaving general practice during the pandemic, followed by an increase in the immediate aftermath. In the 12 months to September 2023, some 8.4% of GPs (by full-time equivalent) left the service – above the low of 6.7% in the 12-months ending June 2021, but not out of line with pre-pandemic levels. However, just under a quarter of GPs under 30 (23.2%) and 9.4% of GPs aged between 30 and 39 left general practice over this period – a number that was only exceeded once in this time series before the pandemic for the latter group.

Figure 1.7 Proportion of GPs (FTE) leaving the NHS, by age band, September 2016 to September 2023



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, GP Joiners and Leavers 2015 – September 2023', supported by CIPFA. Notes: The figures relate to fully qualified GPs who left the NHS in the 12 months up to the relevant date. Data was first published in 2016/17.

Figure 1.8 Change in permanent GP numbers (FTE) since September 2015, by age band



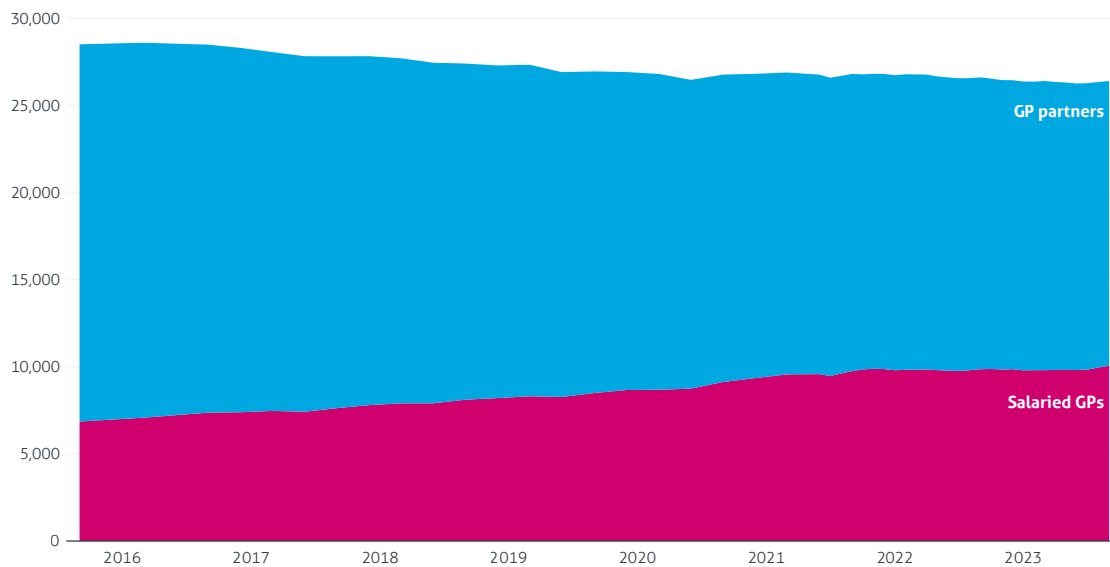
Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – September 2023' (table '2a'), supported by CIPFA. Notes: Data is not available before September 2015. The figures relate to fully qualified permanent GPs.

When leaving rates rise (Figure 1.8) the number of GPs in those age groups will fall unless recruitment increases. Figure 9 shows that poor retention of young GPs, combined with increasing rates of GPs working part time hours, has resulted in the number of fully-qualified, permanent GPs under the age of 40 falling at the fastest rate of any age bracket, with 905 fewer GPs in that group in September 2023 than in March 2016 – an 11.0% decline. In comparison, the overall number of fully qualified permanent GPs declined by 6.9% in the same period. This raises questions about the sustainability of the GP workforce.

The number and proportion of GP partners is at its lowest on record

Declining overall numbers of GPs hides a more nuanced picture when it comes to the split between GP partners and salaried GPs. There were 5,313 fewer GP partners in September 2023 than in September 2015, a fall of just under a quarter (24.5%). In comparison, the number of salaried GPs increased by 3,206 (or 46.7%) over the same period. In September 2023, GP partners accounted for 61.3% of fully-qualified, permanent GPs, compared to 75.0% in March 2016.

Figure 1.9 GP partners and salaried GPs, September 2015 to September 2023



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – September 2023' '1' table), supported by CIPFA. Notes: This is shown in FTEs. Data was not published before September 2015.

There are several reasons why the number of GP partners is declining. First, in common with salaried GPs, trainees and the wider general practice workforce, many partners have experienced high workloads and burnout during and after the pandemic. But, if anything, this story is more severe for GP partners. Many partners might say that they are not only clinicians but also effectively small business owners who manage budgets, employ staff, and lease and maintain premises – all factors which increase stress and burnout.

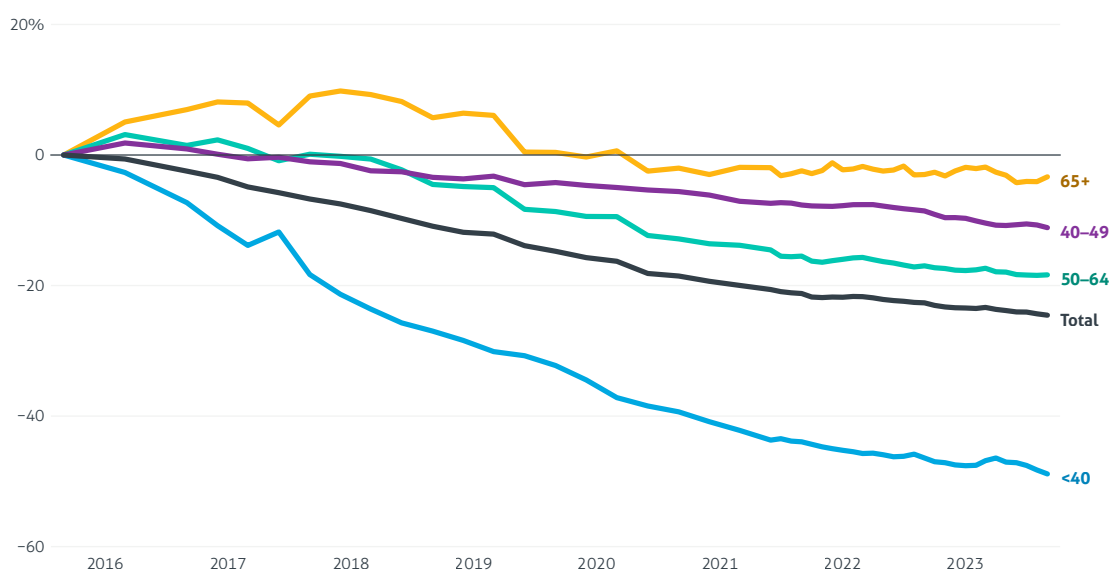
In particular, the financial burden of partnership deters potential partners. That is both in terms of the initial amount to buy into a partnership (for example, by potentially purchasing a portion of the practice premises⁶⁴), but also in terms of the liability that an individual takes on. Most GP partnerships operate as "unlimited liability partnerships",⁶⁵ meaning that a partner is liable for any and all costs associated with the partnership. This also brings with it the risk of being the "last partner standing", wherein every other partner resigns or retires and the practice is unable to recruit any new partners, leaving the final partner with all financial liability.⁶⁶ This creates a potentially vicious feedback loop: as the number of GP partners declines, the financial liability for the remaining GP partners increases, making the prospect of becoming a GP partner less attractive.

There are some solutions that could work to alleviate these disincentives. There is not necessarily a good reason why the partnership model has to operate as predominantly unlimited liability partnerships, and one relatively low cost reform the government could introduce would be to allow for other legal structures – such as limited liability partnerships or companies – to hold the full range of GP contracts.^{67*} This is a proposal that the new chair of the BMA’s GPC for England, Dr Katie Bramall-Stainer, has indicated she would like to explore in the negotiation of the next GP contract,⁶⁸ and which the health and social care select committee recommended in its report *The future of general practice*.⁶⁹

The issue of premises is more complex. In Scotland the government recognised that the upfront cost of entering a partnership and the liability associated with premises ownership was deterring GPs from becoming partners.⁷⁰ In response, it is introducing a scheme that will, in the first instance, allow GPs to take out interest-free loans from the government to release equity on their premises before the government eventually purchases the entire primary care estate by 2043.⁷¹ This would likely help promote partnership in England (and would also have the unintended benefit of giving the NHS greater control over the primary care estate, as discussed above) but would be very costly for the government – in 2019, the NHS estimated that it would cost “a minimum of £5-£6bn” to buy out the GP owned estate.⁷² The Department for Health and Social Care’s entire capital budget for 2023/24 is £10.4bn.⁷³

The result of these disincentives to enter partnerships is that the number of young GP partners has dropped substantially. In September 2023, there were 2,123 GP partners under the age of 40, down from 4,041 in March 2016 – a decline of 48.9%. This is far a steeper drop than the fall in the number of GP partners overall which fell 24.5% in that time and also a greater decline than the overall number of GPs under the age of 40 which fell by 11.3% in the same time.

Figure 1.10 Change in GP partner numbers (FTE) since September 2015, by age band

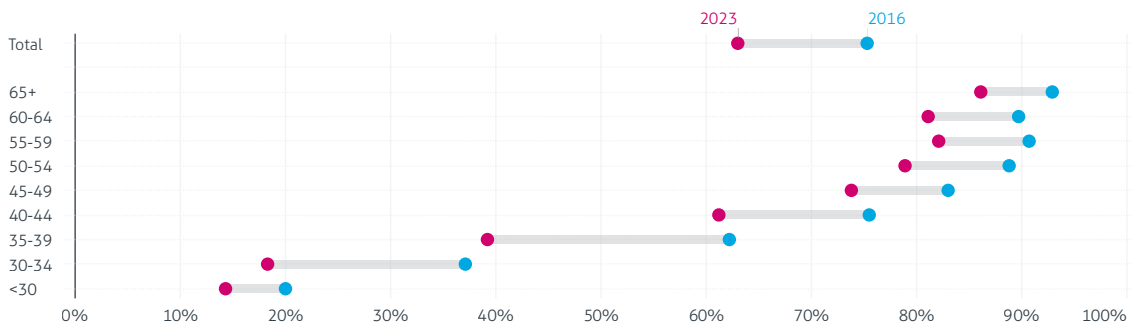


Source: Institute for Government analysis of NHS Digital, ‘General Practice Workforce, England, Bulletin Tables December 2015 – September 2023’ (table ‘2a’), supported by CIPFA. Notes: This shows FTE numbers. Data is not available before September 2015.

* Currently only the minority of GP practices holding what are known as “APMS” contracts can operate as other legal vehicles.

It is not just that there are fewer young GPs and therefore fewer young GP partners; among those GPs who remain in general practice, younger GPs are opting to stay in salaried positions at a far greater rate than they did in 2016. In March 2016, the proportion of GPs that were aged 35–39 and were partners was 62.2%. By March 2023, this had fallen to 39.2% – a 23 percentage point decline. In comparison, there was only a 6.8 percentage point decline among GPs aged over 65.

Figure 1.11 **Proportion of the GP workforce (FTE) that are GP partners, by age band, 2016 and 2023**



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – March 2023' ('2a' table), supported by CIPFA. Note: In each case the month from which the data is pulled is March.

The decline in GP partners is likely contributing to the trend of more practices closing.⁷⁴ In response to a recent RCGP survey, two-thirds of staff (65%) who said that their practice was at risk of closing claimed that it was due to GP partners leaving.⁷⁵ The decline in the number of GP partners also has a more intangible impact; due to their financial investment, they have a strong incentive to make sure the practice is a success. This manifests as partners undertaking more work on average than their salaried colleagues⁷⁶ – or 'discretionary effort', a resource which interviewees told us is invaluable to the functioning of general practice.⁷⁷ Declining numbers of GP partners could mean less of this resource.

On the face of it, the shift towards more salaried GPs – particularly among the younger generation – poses risks to the continuation of the GP partnership model. This could lead to increased calls for a change to the model – a potential route that both the Conservatives⁷⁸ and Labour⁷⁹ have mooted. But it should be stressed that the partnership model is far from doomed; interviewees told us that many of the pressures on GP partners could be alleviated with concerted efforts to remove additional workload and financial pressures from GP partners.⁸⁰

High GP workloads are contributing to greater stress and burnout

According to interviews and surveys of GPs, the factor that contributes to both declining FTE GP numbers and worsening retention rates among younger GPs more than any other is the high workload, which leads to greater stress and burnout. The most recent GP work-life survey (which only shows results from a survey conducted in 2021 and is commissioned by the National Institute for Health and Care Research) shows that increasing workloads and increased demand from patients are the two greatest contributors to stress in the job.⁸¹

It is difficult to accurately capture the number of hours that GPs work per week. Data published by NHS Digital shows that 77% of fully qualified permanent GPs worked less than 37.5 hours per week in March 2023, compared to 66.7% in September 2015.⁸² This would appear to indicate that GPs are working *less* than in the past. But the story is more complex than that. GPs' work often extends outside of their official "working hours", as they are required to catch up on administrative work that they could not complete while they were seeing patients.⁸³ This is so prevalent that many GPs make a formal move to part-time work so that they can work somewhere near to the typical 37.5 hours per week that a full-time GP is supposed to work.

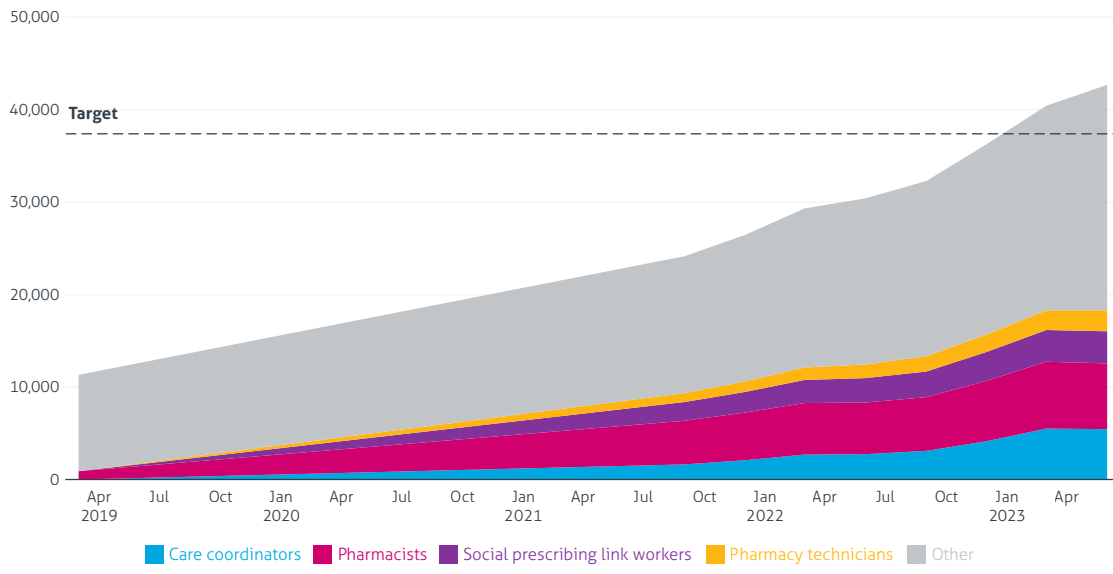
The UK is also an international outlier in terms of GP workloads. GPs in the UK have the lowest level of job satisfaction among comparable countries⁸⁴ and report the highest levels of stress.^{85,86}

Primary care networks and direct primary care staff

The government hit its manifesto commitment target for DPC staff a year early

In 2019, the Conservative Party promised to recruit 26,000 more DPC staff by March 2024.⁸⁷ They did this by providing additional funding through the Additional Role Reimbursement Scheme (ARRS), with the goals of "expanding general practice capacity... improv[ing] access for patients, support[ing] the delivery of new services and widen[ing] the range of offers available in primary care".⁸⁸ The government hit its target in March 2023 – a year ahead of schedule.⁸⁹

Figure 1.12 **Direct patient care staff employed in primary care networks, by staff group, March 2019 to June 2023**



Source: Institute for Government analysis of NHS Digital, 'Primary Care Workforce Quarterly Update' ('1b' table), June 2023, supported by CIPFA.

The increase in DPC staff is not spread evenly across all staff groups. Of the additional 31,370 staff recruited between March 2019 and June 2023, more than half (55.5%) were accounted for by four staff groups: pharmacists, care coordinators, social prescribing link workers and pharmacy technicians. The NHS intends that the largest of those staff groups – pharmacists – independently prescribe/re-prescribe medication and provide medication advice to other healthcare professionals, among other roles.⁹⁰

The full effects of this recruitment drive are unclear

The NHS publishes data on the total number of ARRS staff employed in PCNs, but told us that it does not collect data for the number of appointments carried out by all staff groups, meaning that it is impossible for either us or the NHS to effectively evaluate the efficacy of this recruitment drive.⁹¹ It does, though, seem that the new staff are expanding the types of services offered to patients in primary care, with, for example, more physiotherapists and paramedics than before 2019. This is undoubtedly of benefit to patients.

But it is also unclear what effect the large increase in staff is having on GP workload. Evidence shows that new staff struggled to properly embed in general practice, with a lack of clarity around the roles that many of them would play.⁹² Even when those new employees have been integrated into PCNs they still require extensive management by GPs.⁹³ And while the goal of hiring additional staff was to free up GP time, this is not always the case. Interviewees told us that DPC staff generally carry out tasks that GPs do not typically do themselves (for example social prescribing) rather than ones they do, making it difficult for GPs to shift their own work across to them.⁹⁴ In some cases they do take work from GPs, and the NHS, rightly, told us that it is more appropriate for physios to treat bad backs and for healthcare assistants to do blood tests than GPs.⁹⁵ But in these cases, DPC staff often take on the simpler cases, leaving GPs with the more complex – and therefore more time-consuming and stressful – work.⁹⁶

The large surge in recruitment has meant that PCNs often end up competing with other parts of the health and care sector for DPC staff. This has been most apparent in the recruitment of pharmacists; as the number of ARRS pharmacists has increased, there has been a worsening workforce crisis in community pharmacy.⁹⁷

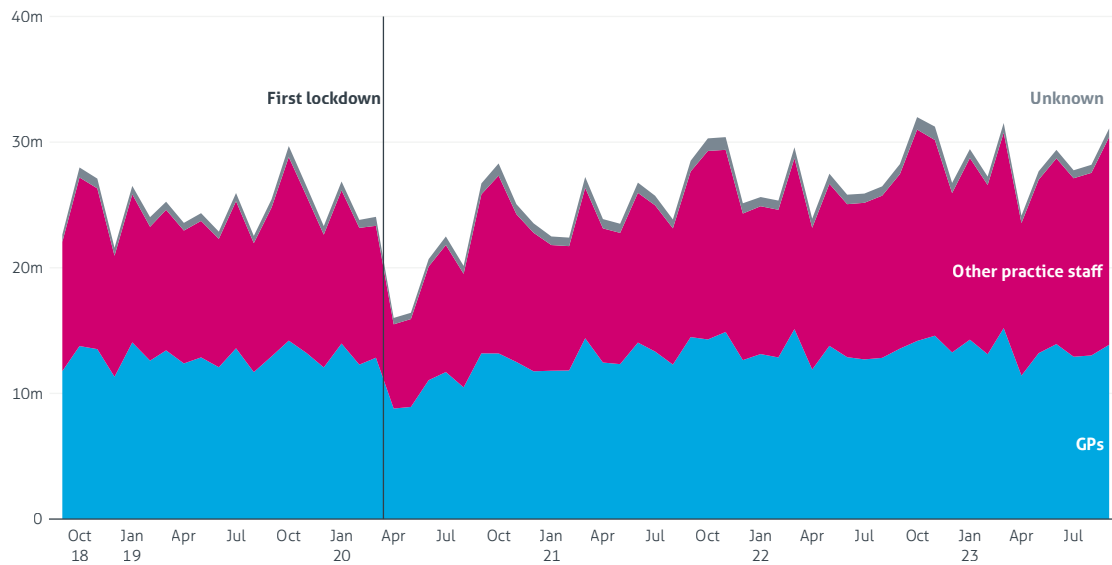
Despite these remaining challenges, the success of the ARRS scheme should not be understated. Interviewees stressed the importance of DPC staff in recent years, with one interviewee saying “it’s hard to think where we’d be without [the additional DPC staff], because of the decline in GP numbers”.⁹⁸ But there is still a way to go before they reach full effectiveness.

Activity

General practice is doing more with less

Despite the noted fall in fully qualified permanent GPs, the number of appointments that GPs delivered reached a record level in 2022/23 – with GPs providing 162.3m appointments, 0.2% more than in 2021/22 and 5.3% more than in 2019/20. Interestingly, this is in contrast to secondary care, where on some measures there is less activity than in 2019/20, despite higher staffing numbers.⁹⁹

Figure 1.13 **Monthly appointments carried out in general practice, by staff group, September 2018 to September 2023**

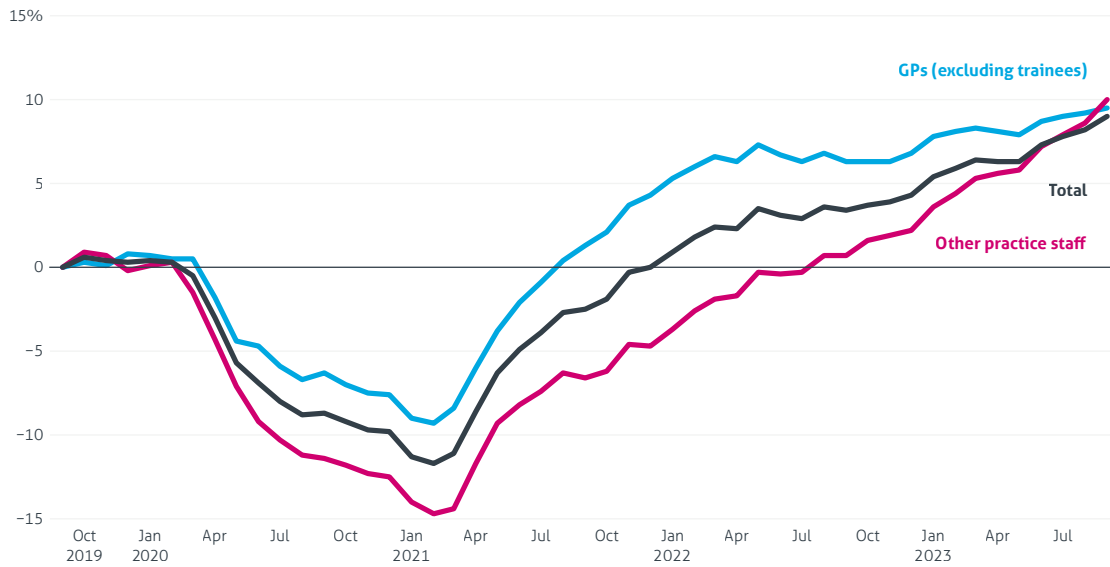


Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, September 2023' ('Table 1'), supported by CIPFA. Note: Data was first published in 2018/19.

Other practice staff are also delivering record numbers of appointments, with 163.3m provided in 2022/23 – an increase of 11.6% compared to 2021/22 and 19.5% compared to 2019/20. This is a far greater increase than the number of GP appointments because of the increase in DPC staff.

Given changing staffing levels, a better metric of activity might be the number of appointments delivered per FTE staff member. According to this metric, both GPs and other practice staff have increased the number of appointments delivered per FTE, with GPs (excluding trainees) delivering 9.5% more appointments per FTE in the 12 months to September 2023 than in the 12 months to September 2019 and other practice staff providing 10.0% more.

Figure 1.14 Change in appointments delivered per FTE in previous 12 months compared to pre-pandemic levels, by staff group

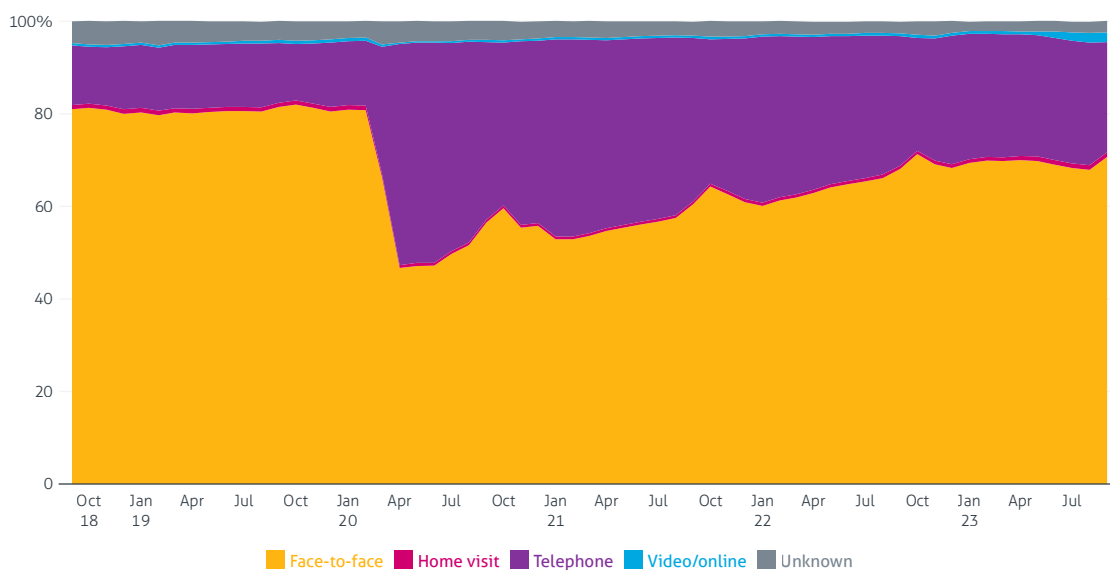


Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, September 2023' ('Table 1'); and NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – September 2023' (table '1a'), supported by CIPFA. Notes: 'Pre-pandemic' here refers to the 12 months to September 2019 as this was the last 12-month period for which there was data before Covid. Data was first published in 2018/19. 'Other practice staff' in this chart is the sum of direct patient care and primary care nursing staff in the GP workforce bulletin.

Remote appointments are falling, but remain above pre-pandemic levels

The way GPs deliver appointments has not returned to pre-pandemic behaviours. In 2022/23, some 29.1% of appointments were delivered by telephone or online compared to 15.2% in 2019/20. But there has been a steady move back towards more in-person appointments since the height of the pandemic: in 2020/21, two-fifths of appointments were delivered by telephone or online (42.0%).

Figure 1.15 GP appointments by mode of delivery, September 2018 to September 2023



Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, September 2023' ('Table 1'), supported by CIPFA. Note: Data was first published in 2018/19.

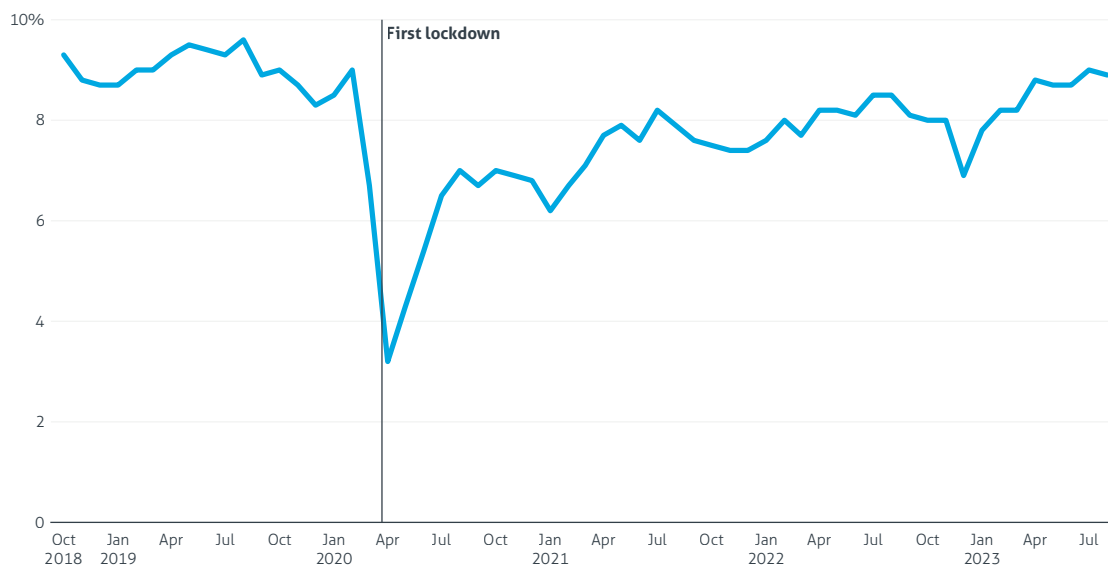
The persistently high level of remote GP appointments – despite NHS guidance that practices should “ensure they are offering face to face appointments”¹⁰⁰ – may be because telephone appointments are popular with the public. Data from AskmyGP, a company that provides triage tools and software to GPs, shows that patients request telephone consultations more frequently than they are given them.¹⁰¹

The UK seems to be an outlier in terms of mode of appointment, delivering by far the greatest proportion of its appointments remotely compared to other countries.¹⁰² There is a potential explanation in that survey – GPs in the UK are also the most likely to think that remote appointments can offer “timely and appropriate care”.¹⁰³

GPs are still referring people less frequently

The rate at which GPs refer patients fell in the first months of the pandemic as GPs attempted to keep patients away from hospitals. The proportion of GP appointments that result in a referral has increased steadily since the height of the pandemic and reached 8.6% in 2022/23, up from 8.1% in 2021/22 – though this is still lower than the 9.2% of attended GP appointments that resulted in a referral in 2019/20.

Figure 1.16 **Specific and acute referrals as a proportion of GP appointments, October 2018 to August 2023**



Source: Institute for Government analysis of NHS England, ‘Appointments in General Practice, August 2023’ (‘Table 1’) and NHS England, ‘Monthly Outpatient Referrals Data, Outpatient Referrals Time-series, August 2023’, supported by CIPFA. Notes: “GP appointments” refers to attended GP appointments. Data was first published in 2018/19.

This reduction is due in part to continued use by GPs of Advice and Guidance (A&G) – a mechanism by which GPs consult with secondary care colleagues about whether or not they should refer a patient before making a referral. The goal of this policy is to reduce the number of unnecessary referrals from primary to secondary care, thereby lowering the number of people on the elective waiting list¹⁰⁴ and improving outcomes for patients.

Since it was introduced in 2019, the number of requests for A&G has risen from approximately 40,000 per month to more than 160,000 in March 2023 – a 300% increase. NHS guidance for 2022/23 set general practice the target of using “specialist advice requests” (which includes A&G) for 16 of every 100 first outpatient attendances.¹⁰⁵ The National Audit Office (NAO) found that general practice has far exceeded that target, with GPs seeking A&G in 22 of 100 first outpatient appointments.¹⁰⁶

Figure 1.17 **GP requests for advice and guidance using the NHS e-Referral Service, January 2019 to March 2023**



Source: Institute for Government analysis of NHS England, 'National advice and guidance data and case reports, March 2023', supported by CIPFA. Notes: The NHS's GP Advice and Guidance (A&G) programme was introduced in 2019. The NHS stopped publishing data for A&G in 2023.

A&G is not just about managing demand out of the system and protecting hospitals from rising demand; there are also benefits for both GPs and patients. For patients, it means they avoid having to wait months or years on an elective waiting list unnecessarily. Interviewees also told us that GPs will almost always refer a patient if they insist on it, meaning that A&G rarely overrides patient wishes. Some GPs like A&G because they feel supported when deciding whether or not to refer a patient¹⁰⁷ – a decision which is often quite stressful, particularly in the context of increasing workloads.¹⁰⁸

Despite this, there are still unanswered questions about what happens to those that end up on A&G pathways. If their condition worsens following a non-referral, they may present again to their GP with the same complaint. Or they may require care elsewhere, for example in the adult social care sector. An RCGP survey showed that 64% of GPs surveyed believed A&G was being used to reduce the elective backlog in secondary care.¹⁰⁹ Even if this route is beneficial to the majority of patients and to the health service, more work needs to be done to understand potential unintended consequences for patients and for the health and care system.

Access

The number of practices continues to decline

There were approximately 6,400 GP practices open in March 2023, down from just over 8,000 in April 2014 – a decline of 20%.¹¹⁰ There is no data for what happens to practices that were previously open, but evidence suggests that most of this decline is due to the merging and takeover of practices, rather than outright closures (some larger practices have multiple sites, but it is impossible to tell from the available data what has happened to the total number of GP sites).¹¹¹

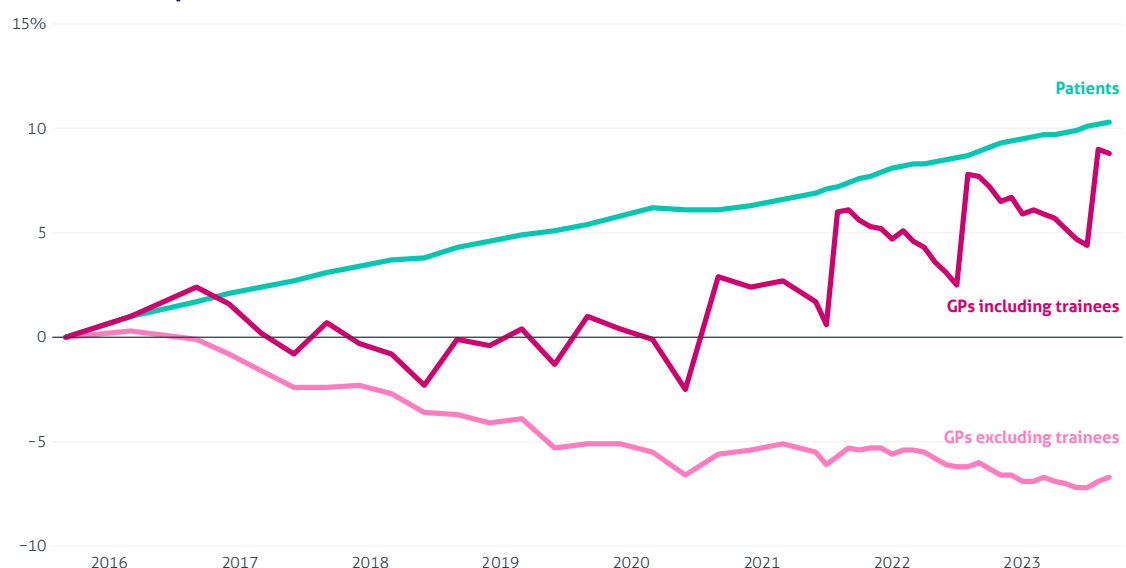
Declining numbers of GP practices mean that patient list sizes have been increasing over the last decade. This means that practices can often find economies of scale. Work from Nuffield Trust says that a “10% increase in patient list size is associated with a 3% reduction in cost per patient”,¹¹² implying that practices with larger list sizes could offer better value for money.

The evidence for patient experience in practices of different sizes is more mixed. Work by the IFS shows that larger practices achieved the highest Quality Outcome Framework (an NHS programme designed to incentivise improved patient outcomes¹¹³) scores, while single-handed practices – by definition the smallest – achieved the lowest.¹¹⁴ The same paper, however, also says that “patients appear to be more satisfied with the care received in small practices, despite objective measures suggesting that they receive worse clinical standards of care”.¹¹⁵

Patient to GP ratios are increasing, and are worse in more deprived parts of the country

At the same time that the number of GPs has been falling, the number of patients registered with practices has increased. The number of patients per GP has risen from 1,990 in September 2015 to 2,340 in March 2023 – an 11.8% increase.

Figure 1.18 **Change in GP numbers and patients registered with GP practices since September 2015**

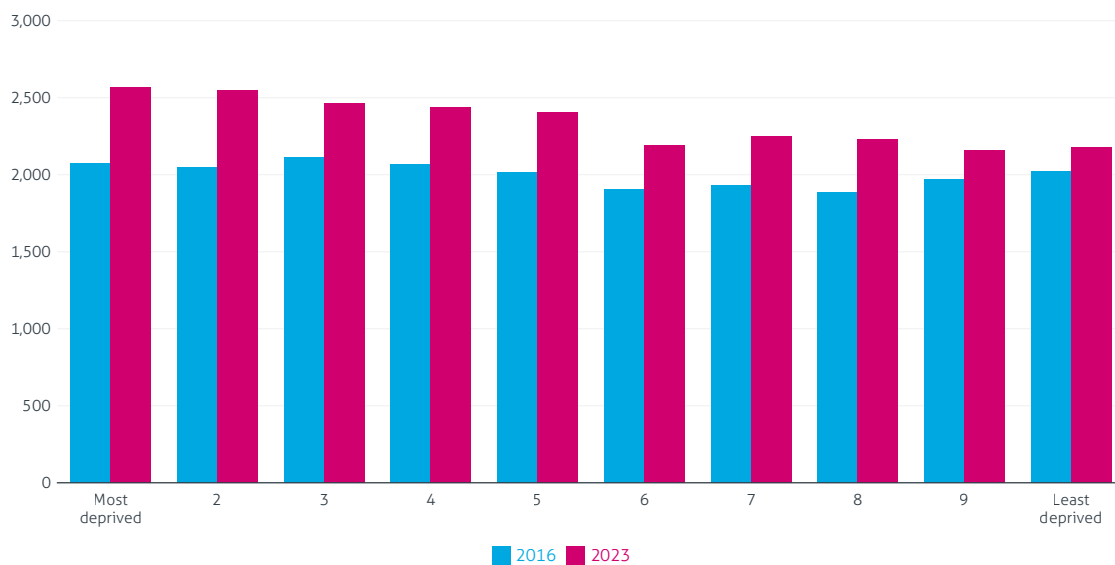


Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables September 2015 – September 2023', supported by CIPFA. Notes: Data was first published in 2015/16. "GPs" refers to the number of fully qualified permanent GPs.

There is, however, no ratio of patients to GPs that is universally accepted as “safe” and the NHS does not provide an opinion on what it deems to be a safe level. Despite this, some argue that patient to GP levels have increased too far. One estimate by a local medical committee (LMC) put the safe ratio of patients to fully qualified permanent GPs at 1,800.¹¹⁶ In March 2023, the patient to GP ratio was 2,340 across England, 30.0% above the safe ratio. The Health and Social Care select committee also recommended returning to personal lists for GPs, to improve continuity of care, and limiting list sizes to 2,500, with the aim of reaching 1,850 over five years.¹¹⁷ This would require the NHS to employ 7,300 more fully qualified permanent FTE GPs – 27.7% more than at present. The government rejected this recommendation in its response to the committee’s report.¹¹⁸

Across England, only a quarter of GP practices had patient to GP ratios less than or equal to 1,800 (24.9%) and 7.8% had ratios of more than 5,000. The increase in the ratio of patients to GP has also been greater in more deprived areas of the country. GP practices in the most deprived decile of the country saw patient to GP ratios rise from 2,073 in 2016 to 2,568 in 2023 – a 23.9% increase. In contrast, the ratio increased from 2,019 in 2016 to 2,180 in 2023 in the least deprived decile, a comparatively small increase of only 8.0%. This has resulted in the most deprived decile of the country having a patient to GP ratio that is 8.7% higher than the least deprived decile in March 2023. In March 2016, it was only 3.1% higher.

Figure 1.19 **Patients per GP, by decile of deprivation, 2016 and 2023**



Source: Institute for Government analysis of NHS Digital, 'Patients registered at a GP practice', March 2023; NHS Digital, 'General practice – practice level staffing', March 2023; and DLUHC, 'English indices of deprivation', 2019, supported by CIPFA. Notes: This analysis is carried out at the lower-layer super output area level. The month of analysis is March in both years.

NHS England has recognised this and is actively trying to recruit more GPs to the most underserved parts of the country through the Targeted Enhanced Recruitment Scheme.¹¹⁹

Larger patient lists for each GP inevitably mean that GPs will be under more pressure to see more patients. The BMA recommends that GPs do not have more than 25 “patient contacts” per day.¹²⁰ This is likewise not a perfect metric of safe working levels, as a “patient contact” can be interpreted in a number of ways and can vary substantially in length. Putting aside concerns about the measure, a report from Policy Exchange in 2022 estimated that GP contacts exceed 37 per day.¹²¹ The rising workload for GPs led the Health and Social Care Committee to conclude in their report *The Future of General Practice* that “patients are facing unacceptably poor access to, and experiences of, general practice and patient safety is at risk from unsustainable pressures”.¹²²

The government’s access plan only helps at the margins

The Sunak government’s *Delivery plan for recovering access to primary care* seeks to address this.¹²³ As the IfG has previously argued,¹²⁴ the measures announced in the plan may improve patients’ experience of phoning practices and booking appointments, but are unlikely to meaningfully improve access. Similarly, shifting work to pharmacists will help free up GP time in the short run, but extra capacity is likely to be consumed by demographic demand pressures in the next few years.¹²⁵

Improving GP access will require investment in general practice. Part of that investment would need to be in the workforce. The recruitment of DPC staff has been successful, as discussed above, but some elements of the service can only be provided by GPs. The NHS has plans to recruit more GPs as part of the *Long Term Workforce Plan*, but this chapter has shown that a large expansion in GP trainee numbers does not necessarily translate into rising numbers of GPs. The plan also does not give any clear indication of the number of GPs that it expects those additional GP trainees to convert into, making it difficult to evaluate the effect that the plan will have on the workforce and, therefore, general practice capacity.

The chapter has also shown that the estate is also not in a fit state for a large expansion of the workforce. The successful addition by the NHS of more than 26,000 DPC staff has not been met with a commensurate increase in the size or appropriateness of the estate.¹²⁶ Until the government solves these issues, it is unlikely that the supply of primary care will keep pace with demand.

2. Hospitals



Hospitals: key figures

- **7.8 million** – the size of the elective backlog in August 2023, 0.5 million higher than when Rishi Sunak promised to cut waiting lists in January 2023 and 3.2 million more than before the pandemic.
- **1.1 million** – hospital appointments rescheduled due to industrial action since December 2022.
- **2** – the number of years between 1970 and 2020 that the UK invested more than the OECD average in health capital.
- **10%** – of people attending A&E in the year to September 2023 waited more than 12 hours, compared to 3.1% in 2019/20.
- **1 in 7** – hospital beds were occupied by someone who was eligible for discharge during the winter of 2022/23.

Introduction

Hospitals have experienced a string of crises in the past few years: Covid, high inflation, one of the worst flu seasons on record, and ongoing industrial action. These have compounded existing performance problems caused by underinvestment in capital, cuts to management capacity and running the system 'too hot'. This has made it impossible for the service to operate normally.

This is evident in the difficulties that the service has had in returning to pre-pandemic activity levels in some areas – a standard of performance that was already well below that of 2010. Hospitals completed fewer elective cases* and outpatient appointments in 2022/23 than in 2019/20. While hospitals carried out more urgent cancer appointments and diagnostic tests, the length of time patients are waiting to receive elective and cancer treatment is higher on average now than it was before the pandemic, and the elective backlog is still growing by around 100,000 cases every month, reaching 7.8 million in August 2023.

Slower flow of patients through hospitals continues to contribute to poor performance of urgent and emergency care, which, while better than during the winter of 2022/23, is still substantially worse than pre-pandemic levels. Better co-ordination across hospitals, general practice, community care and adult social care would help improve hospital discharge and keep people out of hospital in the first place. But

* The technical term for each case on the waiting list is an 'elective pathway', but we choose to use the term 'case' as it is easier to understand.

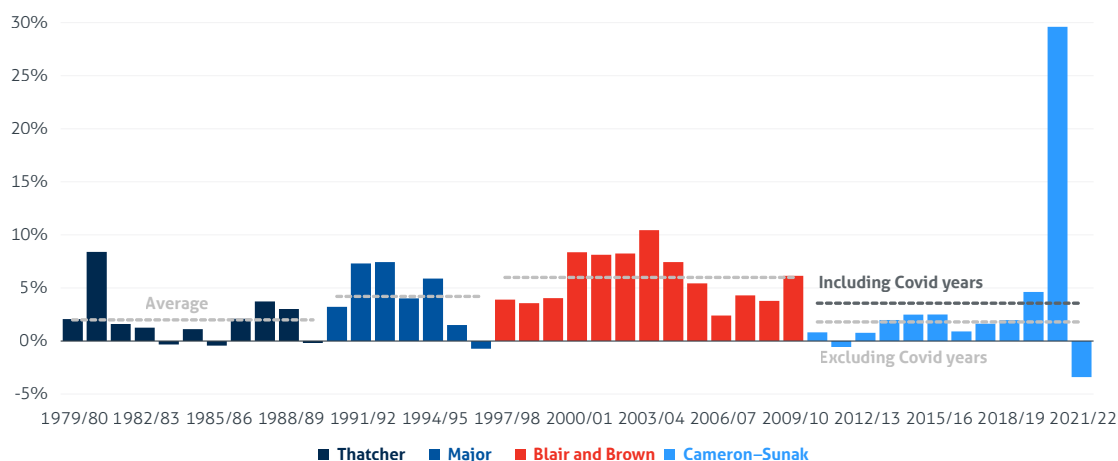
the government has hampered this by cutting the budgets for the management of integrated care systems (ICSs) – the 42 regional bodies that oversee NHS activity across England and the government’s own reform designed to improve co-ordination between services – by 30%, less than a year after placing them on a statutory footing. The need to find the savings required has diverted the already limited management and planning resources of ICSs away from improving integration.

Poor hospital performance comes despite large increases in both spending and numbers of staff. There are more staff than ever working in hospitals, but there has also been a substantial outflow of staff from the service since the peak of the NHS’s pandemic response. To fill the resulting vacancies, the NHS has relied on recruitment from outside the UK and the EU. Replacing experienced staff with inexperienced staff is not a like-for-like exchange. It takes time for new staff to embed in the service and requires more experienced colleagues to train them. The result – for now, at least – is a less productive workforce.

The government is spending considerably more on hospitals than before the pandemic

The period between 2009/10 and 2019/20 was unusual in the history of the NHS for the relatively small increases in spending that government provided. Spending on health* increased on average by 1.7% per year in real terms between 2009/10 and 2019/20, compared to an average increase of 6% per year between 1997/98 and 2009/10, and an average growth of 4.1% between 1949/50 and 2009/10.

Figure 2.1 Annual change in spending on health, 1979/80–2021/22 (real terms)

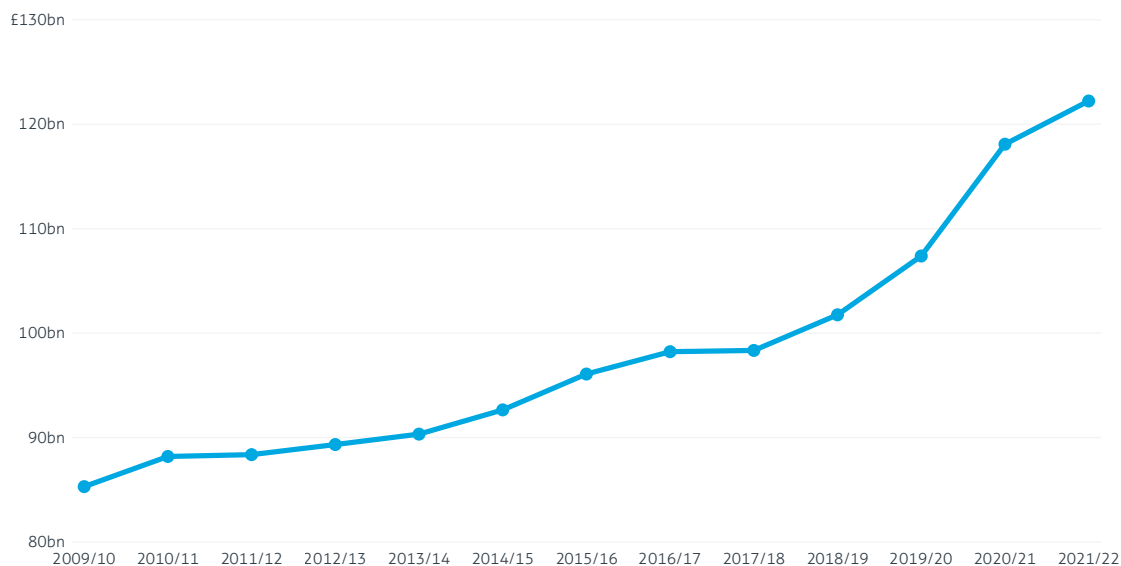


Source: Institute for Government analysis of HM Treasury, *Public Expenditure Statistical Analyses* ('Chapter 5 tables'), 2021/22, supported by CIPFA. Notes: This figure shows health spending in the entire UK.

* The spending measure in Figure 2.1 differs slightly from the measure in Figure 2.2. Figure 2.2 shows spending on NHS providers – the best proxy for hospital spending – in England. The numbers in Figure 2.1 show the increases in the government’s total health spending for the UK, which includes other areas such as general practice. We use this measure for the longer-term time series because there is no comparable data for provider spending that goes back as far as health spending.

Spending on NHS providers – a subset of the spending described above, which is a closer proxy for the money spent on hospitals – rose substantially during the first year of the pandemic – by 9.8% in real terms between 2019/20 and 2020/21. The real-terms increase of 3.3% between 2020/21 and 2021/22 was smaller than the previous year, but still well above the annual average increase of 2.3% between 2009/10 and 2019/20.

Figure 2.2 **Spending on NHS hospitals, 2009/10–2021/22 (2023/24 prices)**



Source: Institute for Government analysis of DHSC annual accounts, 2010/11–2021/22, supported by CIPFA.

Notes: This time series shows spending on NHS providers, which we use as a proxy for hospital spending.

Some of the increase in spending on hospitals since 2019/20 was Covid-related as the government allocated money to help the service deal with the additional pressures associated with it. It is impossible to quantify how much the NHS spent on responding to Covid in hospitals specifically, as estimates such as the National Audit Office's (NAO) Covid tracker are aggregated across the entire NHS.¹ As guidance, the British Medical Association (BMA) estimates that the government provided the Department of Health and Social Care (DHSC) with £47bn of ring-fenced Covid funding in 2020/21 and around £40bn in 2021/22 (though this money is intended for the entire health system, not just hospitals).² This equates to just over a quarter of the money spent on health in 2019/20 – the last year before the pandemic.

Spending would likely have risen more quickly than in the previous decade, even in the absence of the pandemic. The government launched *The NHS Long Term Plan* in 2019,³ which aimed to increase spending by 3.3% per year between 2018/19 and 2023/24 (compared to the 6.3% per year average increase that was seen between 2018/19 and 2022/23).⁴

A substantial portion of this extra spending has gone on staff costs. Spending on staff increased by 11.4% in real terms between 2019/20 and 2021/22, consuming 53.6% of the uplift in spending between those two years.⁵ This is mainly due to the NHS employing more staff, as opposed to rising salaries, as discussed further below.

The government increased funding for the service in the 2022 autumn statement

In the 2022 autumn statement, the government recognised that the NHS requires more funding to meet cost pressures and improve performance, and increased funding by £3.3bn in each of 2023/24 and 2024/25⁶ – representing an increase of approximately 2% in cash terms in each year compared to the previous plans. As a result, spending on the NHS is now expected to grow by 2.0% per year on average in real terms between 2022/23 and 2024/25 compared to the planned increases of 1.4% that the government laid out in the 2021 spending review.

This additional money is for the entire NHS but was stated as being intended to improve emergency and elective performance in hospitals. In particular, the government has set specific ambitions for improving category 2* ambulance response times, elective activity rates, and accident and emergency (A&E) waiting times.⁷

But much of that increase will be spent paying for higher costs due to higher inflation and higher-than-expected wage increases following industrial action. The government estimates that the 5% pay rise for Agenda for Change staff (all staff apart from doctors and the most senior managers working in hospitals) in 2023/24 will cost £1.3bn more than the 3%–3.5% uplift that was originally budgeted for.⁸ In addition, the pay rise for doctors announced in July 2023⁹ will cost approximately £325m more than budgeted for,¹⁰ bringing the total wage bill increase above budget in 2023/24 to £1.6bn – just under half of the uplift announced at the autumn statement. It is unclear, therefore, given the impact of inflation on non-staff spending, if that increase will be enough to expand hospital activity.

This inflationary pressure is partly reflected in the tenuous financial position of a number of ICSs. At the July 2023 meeting of the NHS England board, the chief financial officer reported that 15 of the 42 ICSs had submitted a deficit plan for 2023/24, with a total forecast overspend of £720m.¹¹ This is approximately 0.5% of the £160bn NHS England budget for 2023/24.

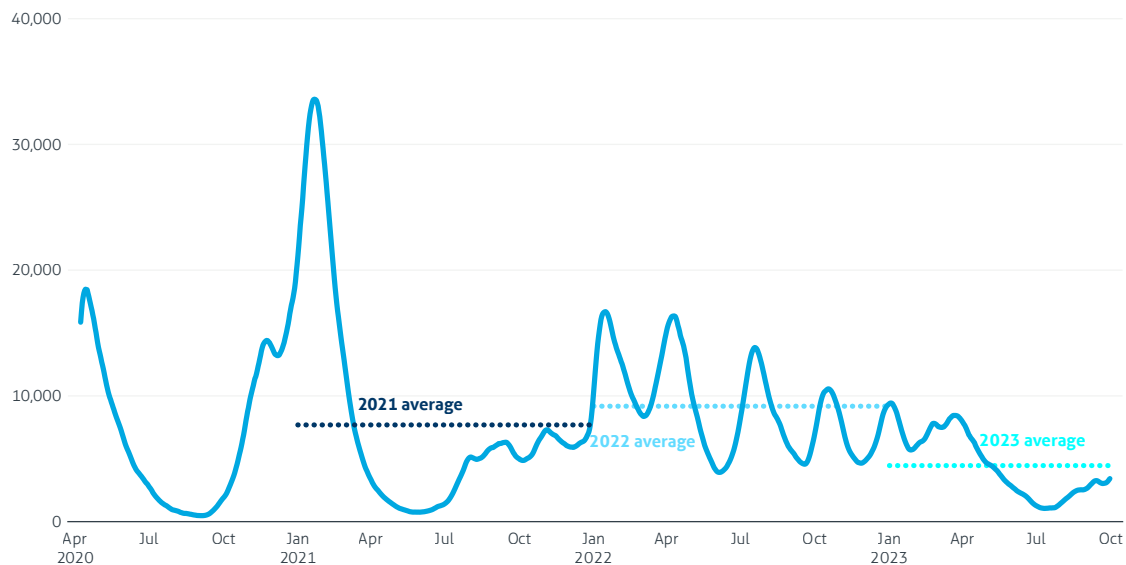
The service is spending less responding to Covid

NHS England relaxed some of its Covid infection prevention and control (IPC) measures in April 2022.¹² But variation between trusts – in, for example, rates of community transmission and the extent of physical changes to the layout of hospitals – meant that Covid measures stayed in place in some trusts longer than in others throughout 2022/23.¹³

The story is different in 2023/24. The vast majority of hospitals have almost entirely rolled back their IPC measures.¹⁴ In addition, the number of people in hospital with Covid has dropped during 2023; the average number of people in hospital with Covid per day was 4,457 to the end of September – 54.3% lower than in the same period in 2022.

* This is the second most severe category and is for serious conditions such as strokes and chest pains.

Figure 2.3 Hospital beds occupied by Covid patients, April 2020 to September 2023



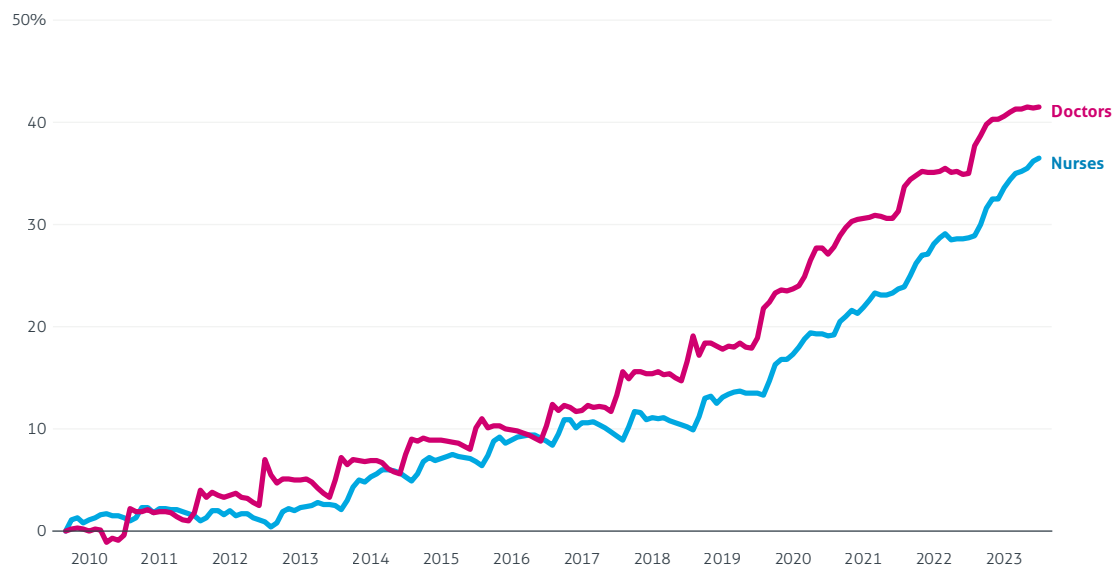
Source: Institute for Government analysis of NHS England, 'Covid-19 hospital activity – monthly COVID publication' ('All beds COVID' table), September 2023, supported by CIPFA. Notes: This solid line represents a seven-day rolling average.

This is positive for hospitals and has arguably happened more quickly than many expected. Fewer Covid-related admissions in hospital means less pressure on beds and improved patient flow through hospitals.

Staff numbers have increased substantially since 2019

In July 2023 there were 20.1% more nurses and 19.9% more doctors working in hospitals and community settings than in March 2019, in full-time-equivalent (FTE) terms.

Figure 2.4 Change in doctor and nurse numbers since 2009



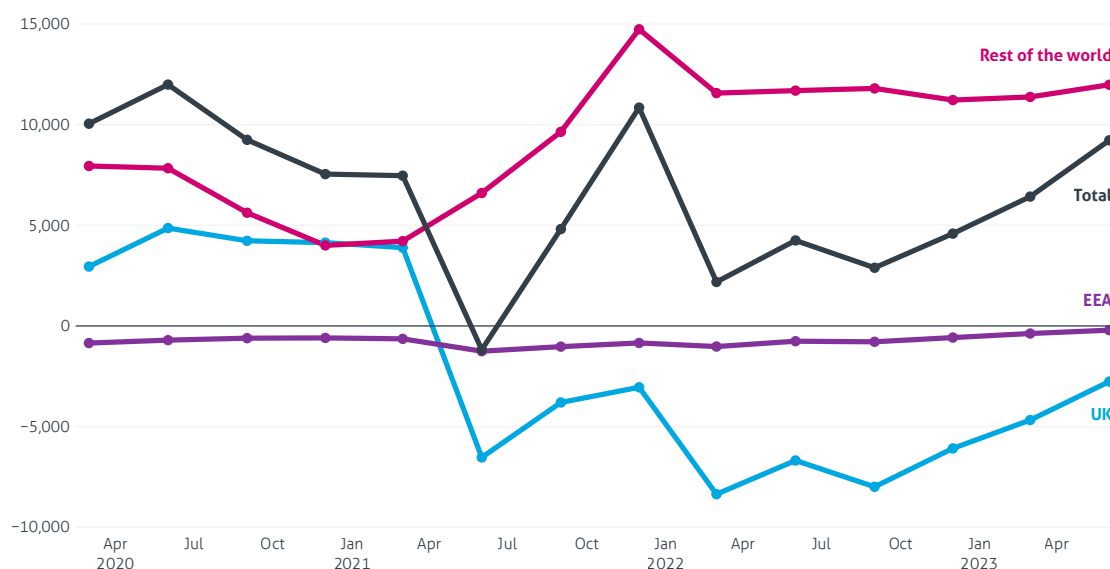
Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics, doctors by grade and specialty', July 2023, and NHS Digital, 'NHS workforce statistics, staff group, care setting and level' ('Nurses and midwives' table), July 2023, supported by CIPFA. Notes: Details on how figures have been produced are provided in the Methodology chapter.

This increase in staffing is largely in line with the NHS's goal to increase the workforce in *The NHS Long Term Plan*, which started from April 2019 and aimed to increase doctor and nurse training places.¹⁵ That ambition was supplemented with the specific goal in the Conservative Party's 2019 manifesto of increasing the number of nurses by 50,000 before March 2025.¹⁶ By July 2023, there were 44,881 more FTE nurses in hospital and community settings than in March 2019, meaning that the government is on track to hit its target by March 2025. The NHS has also recently released its long-term workforce plan, more on which below.

The NHS is relying on international recruitment to grow the workforce

During the pandemic, the source of new nurses and doctors in hospitals changed. More British staff started to leave the service from June 2021 onwards, with their roles then filled by staff from outside the UK and the European Economic Area (EEA). For nurses and health visitors, there were 11,984 net joiners from the rest of the world in the 12 months to June 2023. In the same period, 25,050 British nurses joined the service – a number that is more or less in line with pre-pandemic trends. However, 27,813 British nurses and health visitors left the service, an increase of 11.6% compared to the 12 months to March 2020 (the last pre-pandemic period). This means that there was a net reduction of 2,763 British nurses and health visitors in this time.

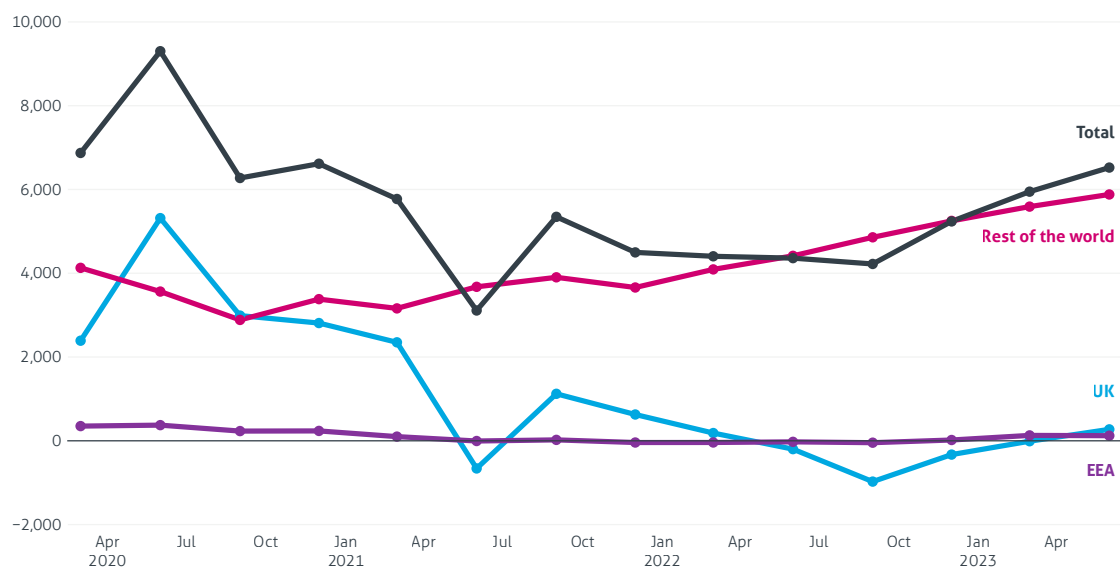
Figure 2.5 **Net nurse and health visitor joiners and leavers in the previous 12 months, by nationality, March 2020 to June 2023**



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics – turnover tables' ('Turnover, age & nationality' table), June 2023, supported by CIPFA. Notes: Figures before March 2020 are not available.

Similarly, among doctors, new recruits from the rest of the world have almost entirely driven the increase in the workforce. Of the net 6,523 joiners in the 12 months to June 2023, 5,881 were from the rest of the world, with only a small net increase (273) from the UK.

Figure 2.6 **Net hospital doctor joiners and leavers in the previous 12 months, by nationality**
March 2020 to June 2023



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics – turnover tables' ('Turnover, age & nationality' table), June 2023, supported by CIPFA. Notes: Figures before March 2020 are not available.

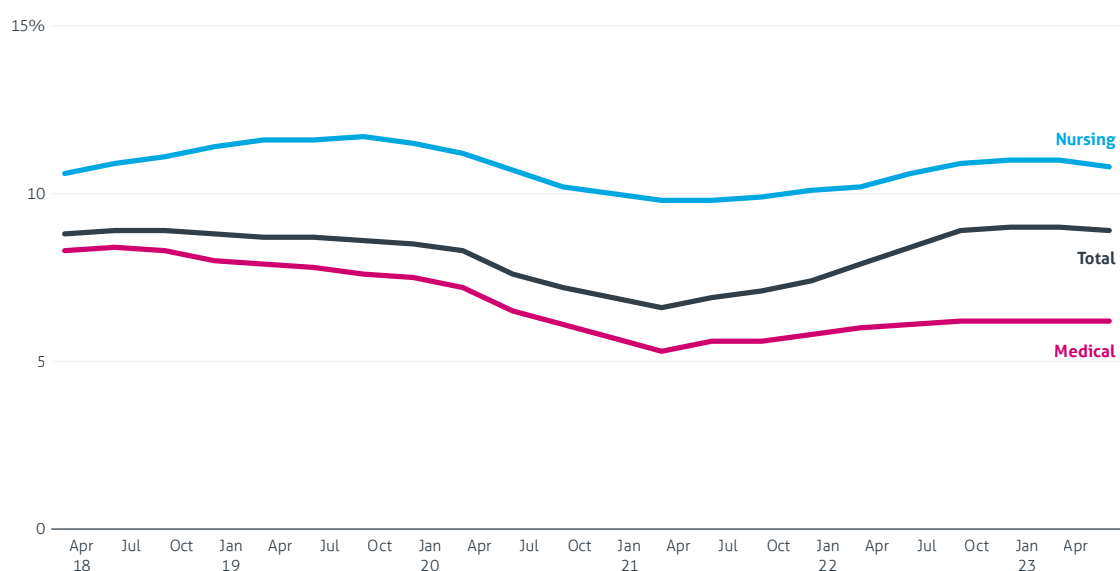
International recruitment is a legitimate route to filling workforce vacancies and is preferable to not being able to staff wards. But it comes with risks. In relation to doctors, those who trained abroad are more likely to give up their licence to practise in the first six years after registering than their British equivalents (who mostly register when they qualify); between 2015 and 2021, 89% of British doctors remained registered, compared to 66% of their international colleagues.¹⁷ However, the opposite is true of nurses. Work from the Nuffield Trust shows that nurses from the rest of the world stay in NHS hospital and community settings for 12 years on average, compared to nine years for British staff and six years for EEA staff.¹⁸

The government also has less control over the future supply of staff when it relies on recruitment from abroad. It cannot mandate that countries train more nurses or doctors and it cannot control the offers that competing countries make to attract a limited international pool of staff. The World Health Organization (WHO) estimates that there will be a global shortfall of 10 million health workers by 2030.¹⁹ This could potentially reduce the ability of countries that are the source of health workers to provide their own effective health service; the WHO says that the "international migration of health workers may exacerbate health workforce shortfalls, particularly in low- and lower-middle income countries".²⁰ There is also a moral question about recruiting staff from countries in need of their own health and care staff.²¹ Finally, immigration is a politically contentious topic, meaning that there could be political pressure in future to reduce the number of health workers coming from abroad. This is shown by recent calls from some parts of the Conservative Party to cut the number of health and social care workers that the government grants visas to work in the UK,²² and for the government to restrict the number of family members that health workers can bring to the UK on their visas.²³

Vacancy rates have mostly returned to pre-pandemic trends

Vacancy rates – which show the difference between the number of funded posts and those that are filled by permanent or fixed-term staff, but do not show posts that are filled by temporary staff²⁴ – fell in hospitals during the early stages of the pandemic, before rising again from the middle of 2021. The total number of vacancies (which includes nursing and medical vacancies, but also vacancies for roles such as health care assistants, porters, management staff, ambulance staff and many others) rose to a high of 9.6% across the health service at the end of both June and September 2022 – the highest level since the NHS started publishing this data in 2017. Since that post-pandemic peak, most vacancy rates have fallen back to largely pre-pandemic levels. For the year ending June 2023, the average vacancy rate across the NHS was 8.9%, which is in line with levels before the pandemic, when they fluctuated between 8% and 9%.

Figure 2.7 **Rolling average of NHS vacancy rates, by type of role, March 2018 to June 2023**



Source: Institute for Government analysis of NHS Digital, 'NHS vacancy statistics England' ('Total 2018 onwards', 'Nursing 2018 onwards' and 'Medical 2018 onwards' tables), June 2023, supported by CIPFA. Notes: NHS vacancy rate data was not published until June 2017. The rolling average is based on figures for the previous 12 months.

The story is similar in nursing, where vacancies reached 10.8% in the year to June 2023, which is only slightly below the 11.2% in the year to March 2020.

Medical vacancies, however, tell a different story. Although these vacancies are slightly above pandemic-era levels, they are well below the levels seen before the pandemic. In the 12 months to June 2023, the average vacancy rate for doctors was 6.2%, compared to 7.3% in March 2020. This seems to be the continuation of a pre-pandemic trend that saw slowly declining vacancy rates in the medical profession; in the 12 months to March 2018, the vacancy rate for doctors was 8.3%.

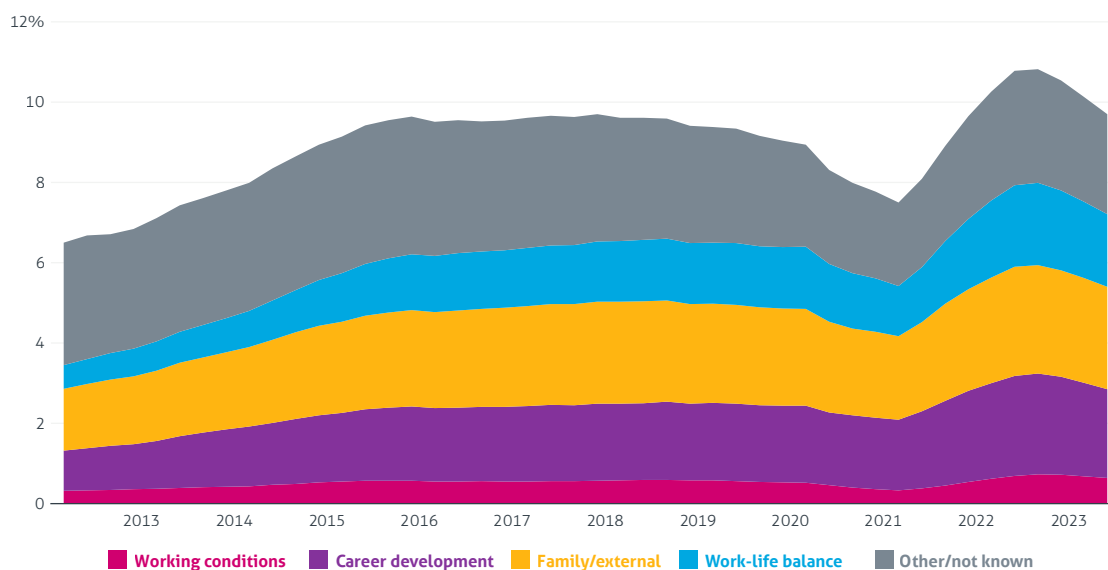
Hospitals often cover vacancies with bank and agency staff. The NHS does not publish regular data on the use of these temporary staff, but the *NHS Long Term Workforce Plan* says that spending on bank and agency staff increased from £3.5bn and £2.4bn in 2018/19 to £5.2bn and £3.0bn in 2021/22 respectively – respective increases of 49%

and 25%.²⁵ Aside from the cost, there is some evidence that heavy use of temporary staff can provide poorer quality care, that it is more difficult for them to work in established teams and that they offer poor value for money.²⁶

Retention worsened directly after the pandemic, but is now improving

The proportion of the workforce resigning voluntarily from their post increased after the first year of the pandemic and reached a peak of 10.8% in the year to September 2022 – the highest level on record – although they may have moved elsewhere in the service. Staff leaving their post has an impact on performance. Previous Institute for Government work shows that high levels of new staff in post likely contribute to lower productivity as it takes time for more senior staff to train them.²⁷

Figure 2.8 **Rolling average of the hospital and community workforce resigning in the previous 12 months, by reason, March 2012 to June 2023**

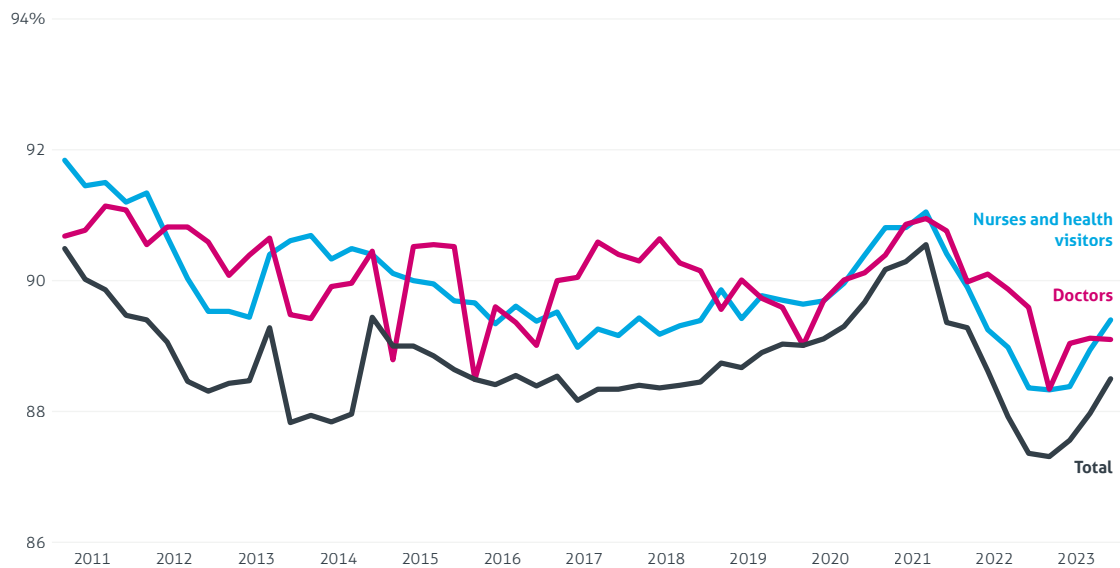


Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics – reasons for leaving' ('Table 1: All reasons for leaving'), June 2023, supported by CIPFA. Notes: Figures before March 2012 are not available. Smaller categories from the original dataset have been grouped into the five seen here and more details are available in the Methodology chapter.

By June 2023, the proportion of the workforce resigning had fallen back to 9.7%, although this is still the joint highest level of any 12-month period before the pandemic.

Staffing instability is also captured by looking at how many people remained in their jobs at the end of a 12-month period, compared to the beginning (Figure 2.9). In the year to September 2022, there was a record low among all NHS staff, among doctors and among nurses and health visitors, with only 87.3%, 88.3% and 88.3% of respective staff groups remaining in the same post for 12 months or more. Although there has been an improvement since then, movement remains higher than before the pandemic.

Figure 2.9 **Rolling average of NHS staff staying in post over the previous 12 months, by staff group, September 2010 to June 2023**

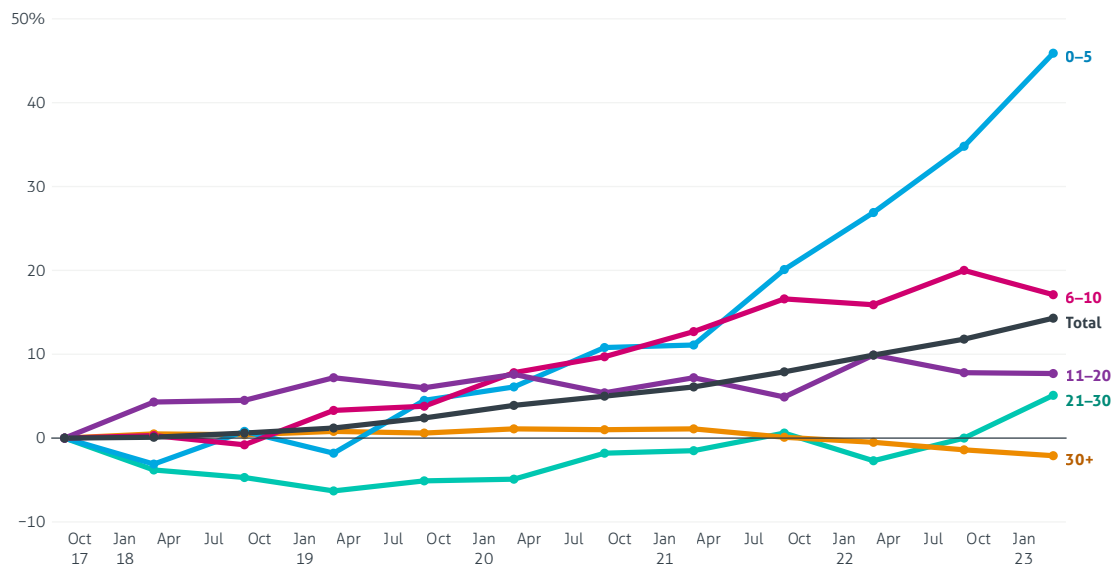


Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics – turnover tables' ('Turnover' table), June 2023, supported by CIPFA. Notes: Foundation-year doctors are excluded because turnover rates for these doctors are artificially high due to frequent role changes.

Staff are less experienced than they were, which may be contributing to poor productivity in the short term

High leaving rates and rising demand for staff over the past few years have driven a surge in recruitment, which means that those currently in post in some staff groups are, on average, less experienced than their predecessors.

Figure 2.10 **Change in numbers of registered nurses since September 2017, by number of years since registration**



Source: Institute for Government analysis of Nursing and Midwifery Council, 'Permanent register data tables' ('Time' table), March 2023, supported by CIPFA. Notes: Figures are only available from September 2017.

Most notably, there was a 31.3% increase in the number of registered nurses who have been on the register for less than five years between March 2021 and March 2023. This compares to a 7.7% increase in the total number of registered nurses over the same period.

This has implications for the effectiveness of staff working in the service. Having more experienced staff members on a ward is associated with better patient outcomes.²⁸ And training new staff drains the time of more experienced colleagues, reducing the time they have available to carry out patient-focused work.

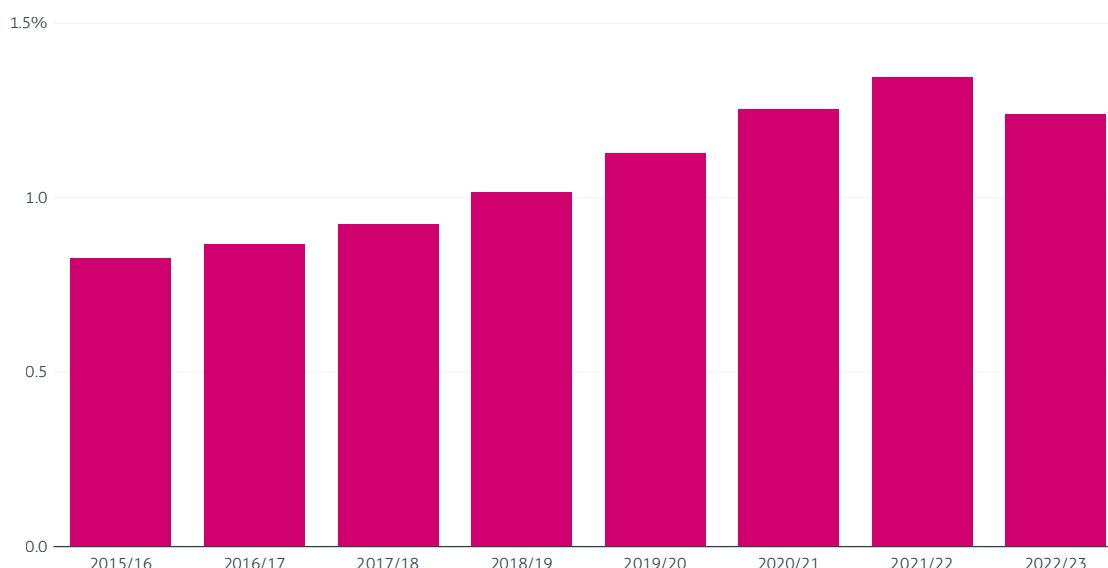
Staff absences have fallen from their pandemic peak, but remain high

The proportion of available staff days lost to illness increased during the pandemic and has remained high since then. In 2019/20, 4.46% of days were lost to illness. This rose to 5.36% in both 2021/22 and 2022/23.

During the pandemic, there was an increase in the number of absences due to both mental health reasons and due to respiratory and other infectious diseases. In 2022/23, 1.24% of staff days were lost due to mental health reasons; this was an improvement on 2021/22, when 1.35% of days were lost for this reason, but still 10.0% higher than 2019/20, when it was 1.13%.

While there was a sharp increase in days lost to mental ill health during the pandemic, it followed a number of years of gradually increasing proportion of staff days lost to that reason: in 2015/16, only 0.83% of staff days were lost to mental ill health. Though difficult to directly compare, it seems as though the rates of mental ill health in the NHS have worsened faster than in the general population. In 2015/16, 0.46 days per worker were lost to stress, depression or anxiety in Great Britain. This rose to 0.48 in 2018/19, an increase of 4.3%.^{*29} In comparison, the proportion of working days in hospitals lost due to mental health reasons increased by 22.6% in the same time.

Figure 2.11 **Proportion of NHS staff days lost to mental ill health, 2015/16–2022/23**

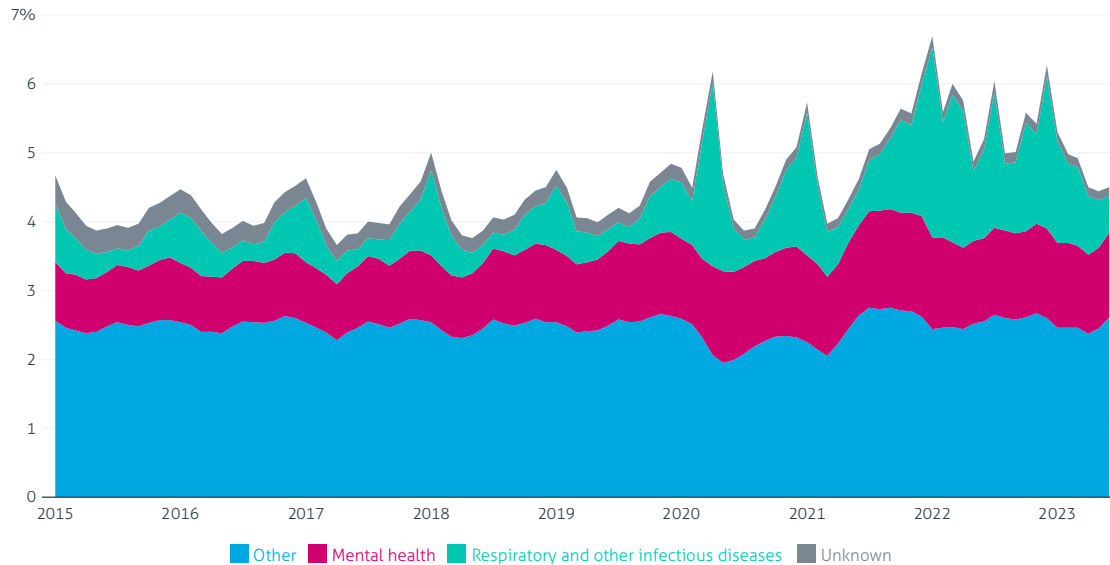


Source: Institute for Government analysis of NHS Digital, 'NHS sickness absence rates' ('Table 2: Count'), March 2023, supported by CIPFA.

* We use this year because the Health and Safety Executive, which publishes the time series, says that data is less comparable from 2019/20 onwards due to Covid.

The rise in absences due to respiratory and other infectious diseases is even more notable. In 2022/23, 1.43% of staff days were lost for this reason, up from 1.35% in 2021/22 and just 0.60% in 2019/20.

Figure 2.12 NHS staff absence, by reason, January 2015 to June 2023



Source: Institute for Government analysis of NHS Digital, 'NHS sickness absence rates' ('Table 2: Count'), June 2023, supported by CIPFA. Notes: Data before 2015 is not available. Details on how the figures have been produced are provided in the Methodology chapter. 'Respiratory and other infectious diseases' includes colds, coughs and flu.

The continued prevalence of absences due to respiratory and other infectious diseases throughout 2022 occurred despite substantially fewer staff absent due to Covid in 2022/23 than in 2021/22: the average number of staff absent per day for that reason fell from 24,379 in 2021/22 to 5,600 in 2022/23.³⁰ The persistence of respiratory and other infectious disease absences is therefore likely to be the result of a particularly bad flu season in the winter of 2022/23.³¹ Though there is no data for the number of staff absent with flu, the prevalence in the population seems to have been much higher in 2022/23 than in 2021/22; the government estimates that there were 49,300 admissions due to flu in 2022/23 compared to 8,400 in 2021/22³² – an increase of 486.9%.

Poor pay and conditions are driving low staff morale

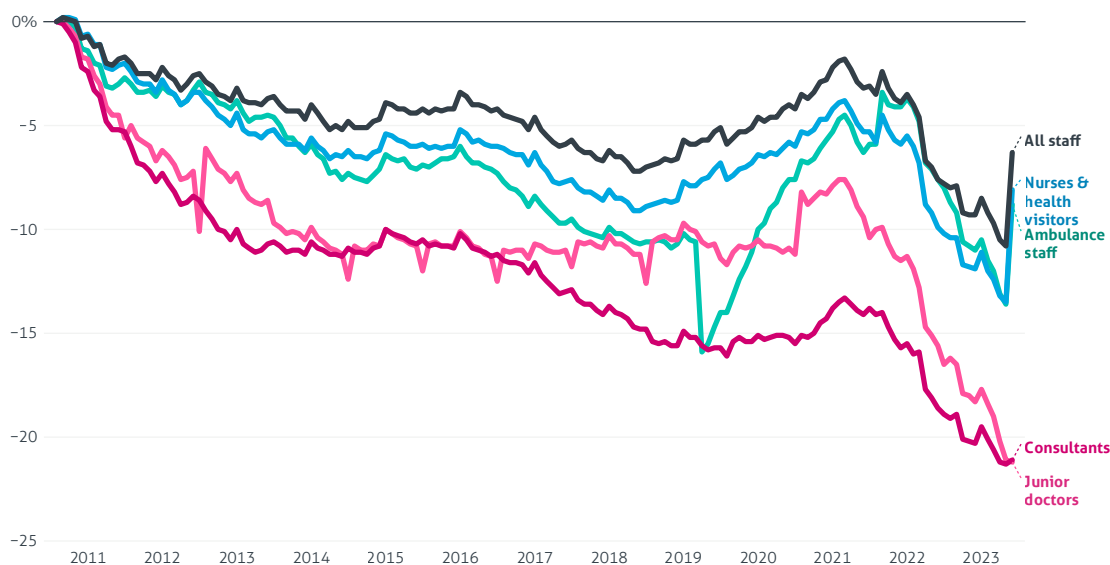
The pandemic has had a large negative impact on working experiences, with many staff suffering burnout from the stressful working conditions and 'moral injury' – a feeling of guilt or anger that arises from an individual being forced to do something that violates their moral values.^{33,34,35} In the case of health care workers, this sense of moral injury largely arose from an inability to deliver the level of care they believed patients should receive due to high demand and a lack of resources.

It is not just the pandemic, though, which has contributed to declining morale in the service. There is evidence of a poor working culture within some hospitals. A report by the General Medical Council (GMC) found that 12% of trainee doctors had "been intentionally humiliated in front of others", with the number reaching 19% for trainees in surgical posts.³⁶ That data supports the anecdotal evidence reported in *The Times* of widespread sexism among surgeons.³⁷ The Messenger review – a government-

commissioned review into leadership across health and social care – found that “acceptance of discrimination, bullying, blame cultures and responsibility avoidance has almost become normalised in certain parts of the system”.³⁸

Among the variables we looked at, satisfaction with pay is the metric that has seen the largest and most sustained decline in staff satisfaction across the NHS. It was down 10.6 percentage points in 2022 compared to 2017, with only a quarter of NHS staff reporting being satisfied with their pay.

Figure 2.13 Real-terms change in NHS staff earnings, by staff group, since August 2010



Source: Institute for Government analysis of NHS Digital, 'NHS staff earnings estimates' ('Table 2b'), June 2023, and ONS, 'Consumer price inflation time series', June 2023, supported by CIPFA. Notes: This is earnings per person in the NHS, a measure that includes basic and additional pay. 'Ambulance staff' refers to a combination of the NHS staff groups 'Ambulance staff' and 'Support to ambulance staff', which we use because there was a reclassification of some ambulance staff into support staff in April 2019, which artificially inflated the average earnings of ambulance staff.

This dissatisfaction with pay is likely to be partly explained by the large real-terms decline in hospital staff pay since 2010. The earnings of nurses and health visitors fell by 13.5% in real terms between August 2010 and May 2023, before recovering slightly in June 2023 to 8.1% beneath 2010 levels. This sharp jump in June 2023 is because that is when the NHS paid staff the one-off bonuses that unions and the government agreed in March.³⁹ Between August 2010 and June 2023, consultants' and junior doctors' earnings fell by 21.1% and 21.2% in real terms respectively.

Even though consultant pay has fallen the second furthest since 2010, that year did come at the end of a period of sustained wage growth for senior doctors. In cash terms, consultant earnings per FTE grew from £68,350 in 1998/99 to £119,729 in 2008/09, which represents a real-terms increase of more than 45%.⁴⁰ Even with those falls in real-terms pay, consultants remain in the top 3% of the income distribution.⁴¹ However, consultants will likely feel aggrieved that their pay has fallen by more than a fifth in real terms since 2010.

The government has taken steps to redress some of these falls, with the decision to award consultants a 6% pay increase and junior doctors somewhere between an 8.1% and 10.3% pay increase (depending on their level of training) in 2023/24⁴² – both of which are above forecast levels of inflation for 2023/24.

Long-running industrial action is hampering pandemic recovery

Dissatisfaction with pay and with wider working conditions are the two primary contributing factors to industrial action that started in summer 2022 and is ongoing at the time of writing. In that time, non-medical hospital staff, junior doctors and, most recently, consultants have all walked out at some point.⁴³

As discussed in the 'Cross-service analysis' chapter of this report, the government's strikes strategy has likely extended industrial action, which has badly hampered hospital activity. One interviewee told us that for every three-day junior doctor strike, the NHS loses between 1% and 2% of its total elective activity for the year.⁴⁴ Since December 2022, the NHS has rescheduled more 1.1 million appointments due to strike action.⁴⁵ But the dataset showing rescheduled appointments does not capture the appointments that are not made after the NHS knows that strikes will go ahead, meaning that there will have been other appointments that would have gone ahead without industrial action.

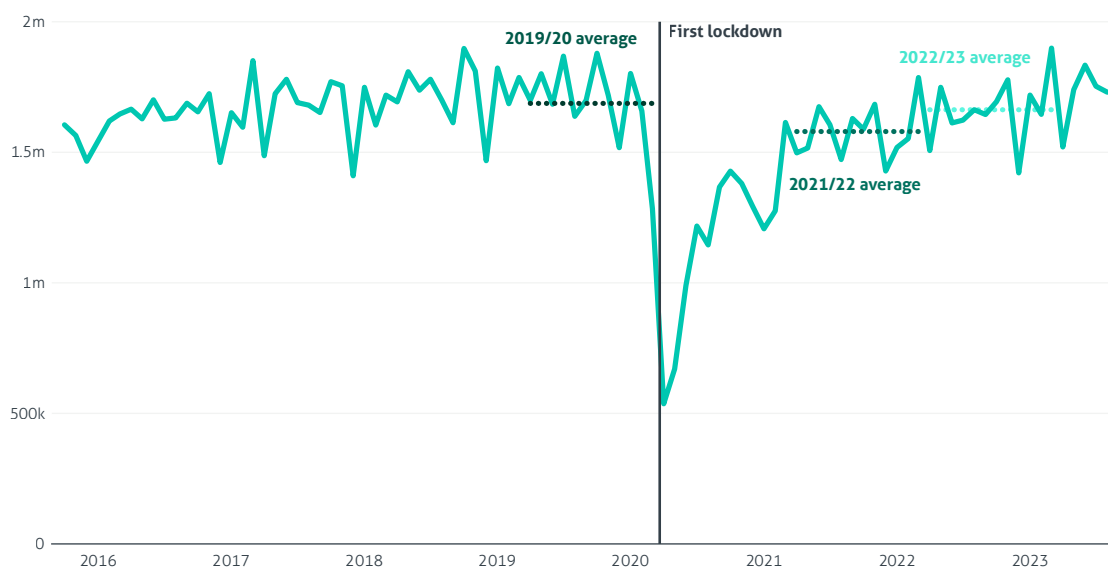
The burden of strikes extends beyond just the lost activity. It costs the NHS more than usual to backfill the shifts that striking staff leave unfilled, predominantly through having to pay senior staff a premium to work in those times. The NHS estimated that the April junior doctors' strike had a total financial impact of £360m (on a budget of £167bn) and that it means the NHS can afford 2% less elective activity across the entire year.⁴⁶ Finally, there is a large but unquantifiable opportunity cost of the strikes. Responding to strike action occupies management time across trusts,^{47,48} reducing the resources that could otherwise be spent on other initiatives to reduce waiting lists or improve hospital performance.

The continuation of the strikes therefore threatens the government's target for bringing down waiting lists. NHS England has recognised this threat to the target by reducing trusts' elective activity targets for 2023/24 from 107% of pre-pandemic levels to 105%,⁴⁹ and providing £350m of funding to trusts to compensate them for money lost from reduced activity.⁵⁰

Demand for elective treatments is lower than expected

During the pandemic, many expected there to be a surge of demand for elective care as lockdowns were lifted, but that influx has not materialised.

Figure 2.14 Additions to the elective waiting list, October 2015 to August 2023



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Full time series' table), August 2023, supported by CIPFA. Notes: Figures before October 2015 are not available.

The average number of monthly additions to the elective waiting list in 2019/20 was 1,687,243. But in 2021/22 and 2022/23 the NHS had not yet returned to that rate, averaging 1,579,485 and 1,662,878 per month respectively. This is despite the expectation during the pandemic that pent-up demand would result in a large surge in people being added to the elective waiting list.

There are several reasons for this. First, the NHS has increased its use of 'advice and guidance' (A&G) – where a GP consults with a secondary care colleague before making a referral, discussed in more detail below. This has resulted in a lower referral rate from GPs to secondary care (see GPs chapter for more details). According to a report from the NAO, the NHS expects that increased use of A&G will result in 1.4 million fewer additions to the waiting list in 2023/24⁵¹ – roughly 7% of the total new additions in 2019/20. Second, even though GPs are conducting more appointments than ever, it seems as though capacity is still not meeting demand. This means that people who a GP might have referred to the elective waiting list have not been referred still, due to delays in accessing care. Finally, interviewees hypothesised that people may be less likely to come forward for care for minor issues than they were before the pandemic – due, for example, to being deterred by messaging about pressures on the NHS – though this is very hard to quantify.⁵²

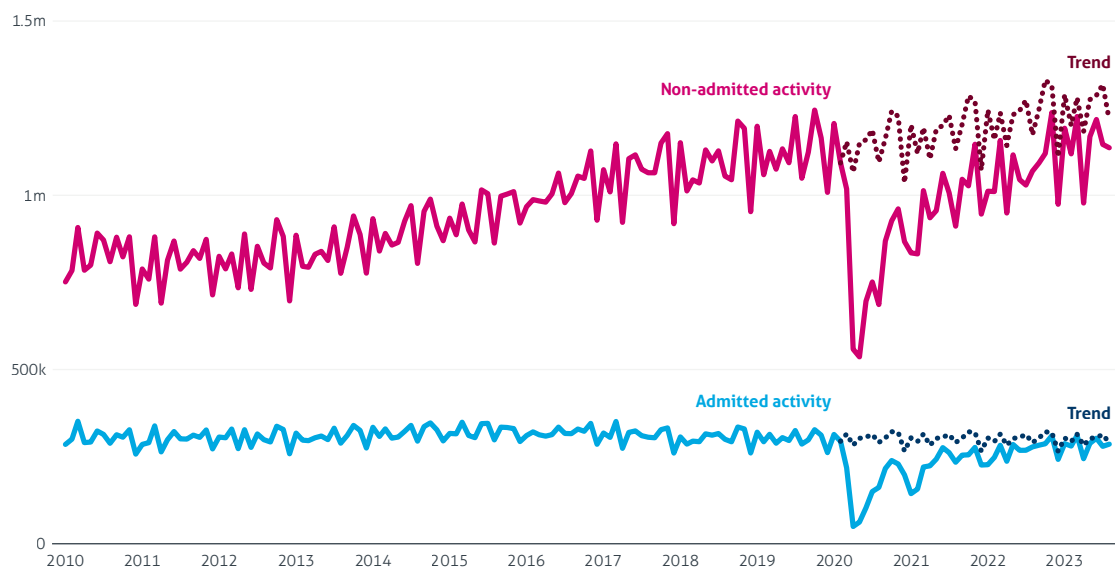
In its delivery plan for tackling the elective backlog, published in February 2022, the NHS estimated that it would need to deliver 30% more activity by 2024/25 than before the pandemic to start to reduce the waiting list for elective care.⁵³ In more recent work, the Institute for Fiscal Studies (IFS) estimates that due to the lower-than-expected number of people being added to the waiting list – in particular due

to increased use of A&G – the NHS would now need to increase elective activity by 20.9% to achieve the same outcome.⁵⁴ This would still be an enormous increase in activity, but is substantially less than the NHS’s original estimate.

Elective activity has increased in the past year but is still below pre-pandemic levels

After a substantial drop in 2020/21, the NHS is slowly managing to increase elective activity. Hospitals completed 3.3 million admitted cases and 13.2 million non-admitted cases in 2022/23, an 11.0% and 7.8% increase respectively from 2021/22. Despite the year-on-year increase, 2022/23 activity levels were still below the levels achieved before the pandemic, even though there have been large increases in funding and staffing. Hospitals completed 5.3% and 2.0% fewer admitted and non-admitted cases in 2022/23 than in 2019/20. The first five months of 2023/24 (to the end of August 2023) show that the gradual improvement from the worst days of the pandemic is continuing. The NHS completed 1.2% more non-admitted cases between April and August 2023 compared to the same months in 2019. There were 6.7% fewer admitted cases, but this is also roughly in line with the trend of declining numbers of admitted cases that predated the pandemic, due to a shift towards non-admitted procedures where possible. While this improvement is welcome, it still leaves activity beneath where we expect it to be if the pre-pandemic trend of increasing activity had continued.

Figure 2.15 **Elective activity by type, January 2010 to August 2023**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Full time series' table), August 2023, supported by CIPFA. Notes: The 'trend' lines are seasonal forecasts, using pre-Covid data as the baseline.

Interviewees told us that a succession of crises hampered efforts to increase activity following the disruption of Covid. First, there was the cost-of-living and inflation crisis, which meant tight budgets constrained activity. Second, interviewees said that the churn of secretaries of state throughout the summer and autumn of 2022 created inconsistent policy making and hampered preparations for the winter. This is evident in the late announcement of additional financial support for delayed

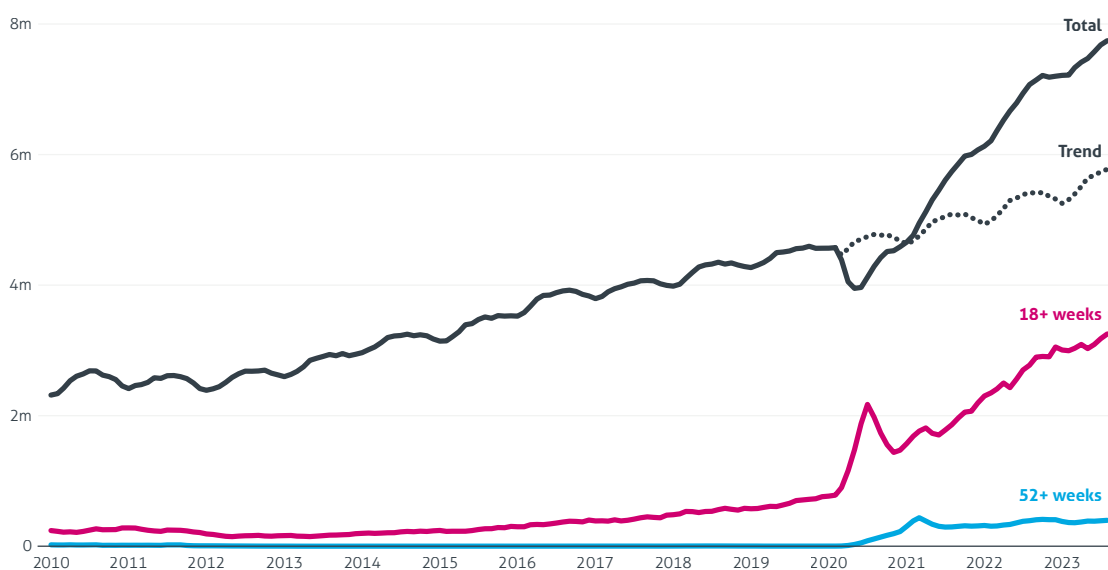
discharge in January 2023. Third, the winter also saw one of the worst flu seasons in recent history,⁵⁵ which further constrained capacity. Finally, as discussed above, the wave of industrial action across the service is reducing the amount of elective activity that can take place.

The elective waiting list is still increasing

Relatively low activity means that the elective waiting list is still growing, even with lower-than-expected demand. Despite a slight flattening out between November 2022 and February 2023, there were consistent increases in the waiting list between March and August 2023, meaning that the waiting list stood at 7.75 million incomplete cases at the end of August 2023 – the highest level on record and 69.3% higher than the 4.57 million in February 2020. Even before the onset of the pandemic, the waiting list had grown steadily since 2010, rising from 2.53 million in April 2010 to 4.57 million in February 2020 – an increase of 80.4%.

The waiting list counts the number of incomplete cases, meaning that someone could be on the list more than once, for multiple reasons. At the end of May 2023, NHS England estimated that of the 7.5 million cases then on the elective waiting list, the number of unique individuals was 6.3 million.⁵⁶ There is no more recent data than May as NHS England has stopped publishing that piece of information.

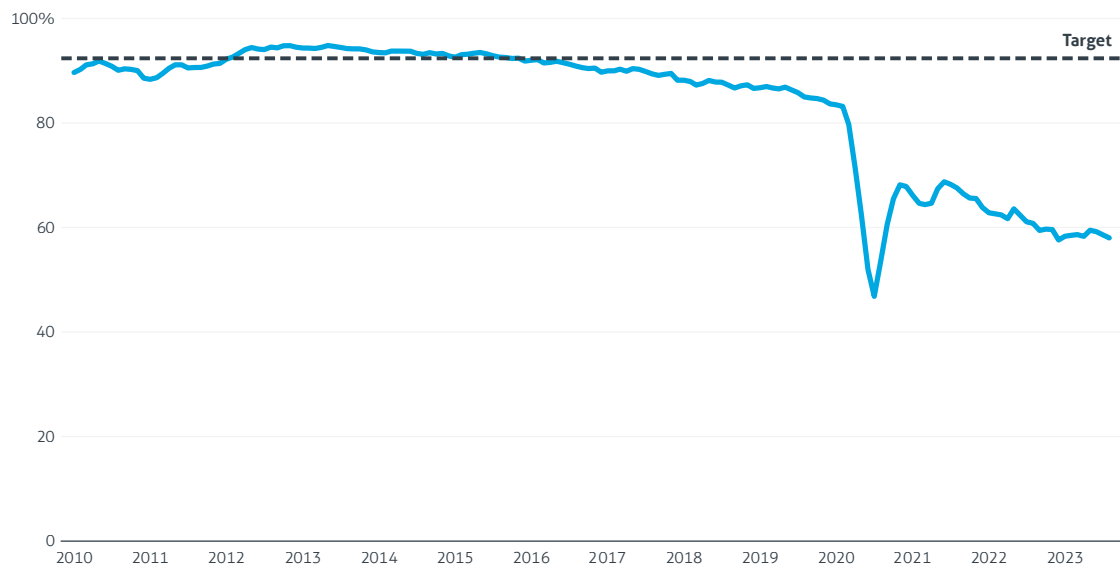
Figure 2.16 **Elective waiting list length, by length of wait, January 2010 to August 2023**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Full time series' table), August 2023, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

People are also more likely to stay on the waiting list for longer than before the pandemic. The proportion of people treated within 18 weeks of a referral has steadily declined since 2019/20. In 2022/23, only 60.1% of pathways were completed in less than 18 weeks, down from 84.2% in 2019/20 and well below the target of 92%. Once again, poor performance predates the pandemic. The last time the NHS hit this target was February 2016.

Figure 2.17 **Elective cases completed within 18 weeks of joining the waiting list, January 2010 to August 2023**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Full time series' table), August 2023, supported by CIPFA.

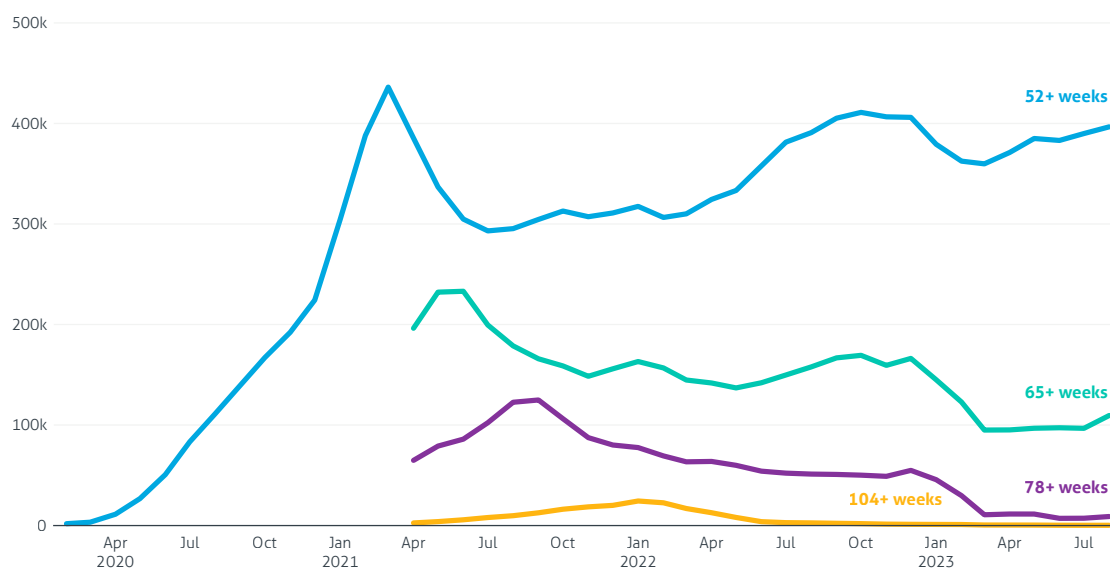
The NHS missed the first two of its elective recovery targets, and is not making enough progress on reducing waiting times

According to the NHS backlog recovery plan, the NHS aims to deal with everyone who has been waiting a long time for treatment by the end of the following months:⁵⁷

- people waiting 104 weeks or more by July 2022
- people waiting 78 weeks or more by April 2023
- people waiting 65 weeks or more by March 2024
- people waiting 52 weeks or more by March 2025.

The NHS missed the first two of these targets. By the end of August 2023, there were still 8,998 people who had been waiting at least 78 weeks for elective treatment, down from 10,737 in March 2023, but an increase on July. The NHS came closer to hitting the target for 104-week waits, eliminating all but 2,890 by the end of July 2022.

Figure 2.18 Incomplete elective cases, by length of wait, February 2020 to August 2023



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Full time series' table), August 2023, supported by CIPFA. Note: Data for 65-, 78- and 104-week waits was not available before April 2021.

NHS England claimed that the target for 78-week waits was missed due to junior doctor strikes.⁵⁸ While strikes are certainly reducing elective activity, work from the *Health Service Journal* shows that junior doctor strikes only accounted for approximately 2,000 of the 10,737 people waiting at least 78 weeks at the end of March 2023,⁵⁹ meaning the NHS would have missed the target even if junior doctors had not been striking. That said, some leeway should be given to hospitals on these targets – some people choose not to accept care at a time when the NHS offers it to them, meaning they remain on the list longer than they might have, and the complexity of some other cases means hospitals cannot quickly clear them off the list.⁶⁰

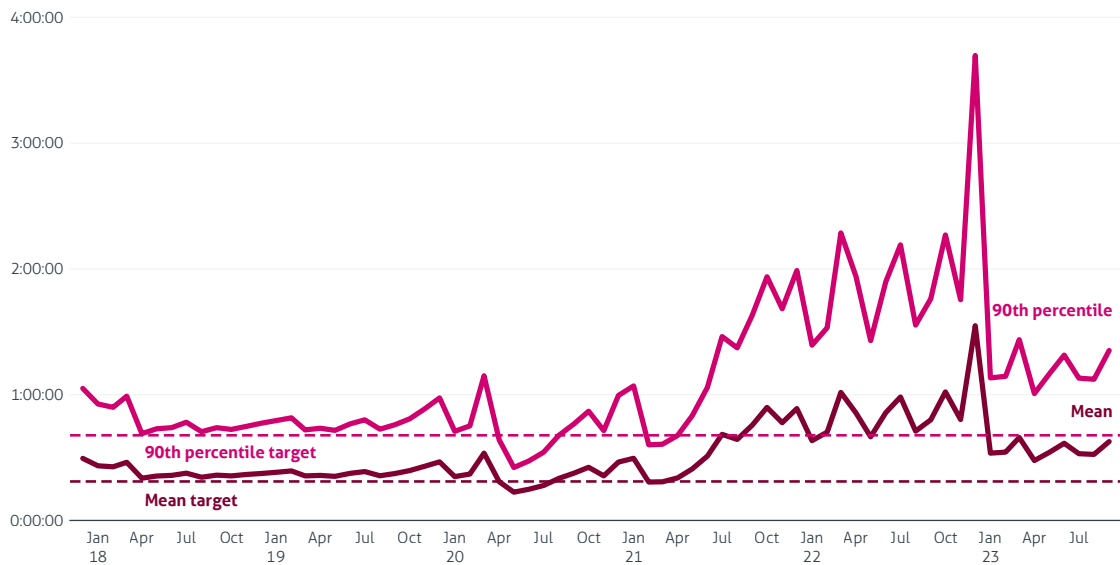
However, between March and August 2023, the number of people waiting 65 weeks or more grew by 15,079 (or 16.0%) and the number waiting at least 52 weeks grew by 37,565 (or 10.5%).

Political turmoil in 2022 contributed to arguably the worst winter in NHS history

The NHS experienced arguably the worst winter in its history during 2022/23.⁶¹ December 2022 saw historic lows in ambulance response times, and historically long A&E waiting times and ambulance handover delays.

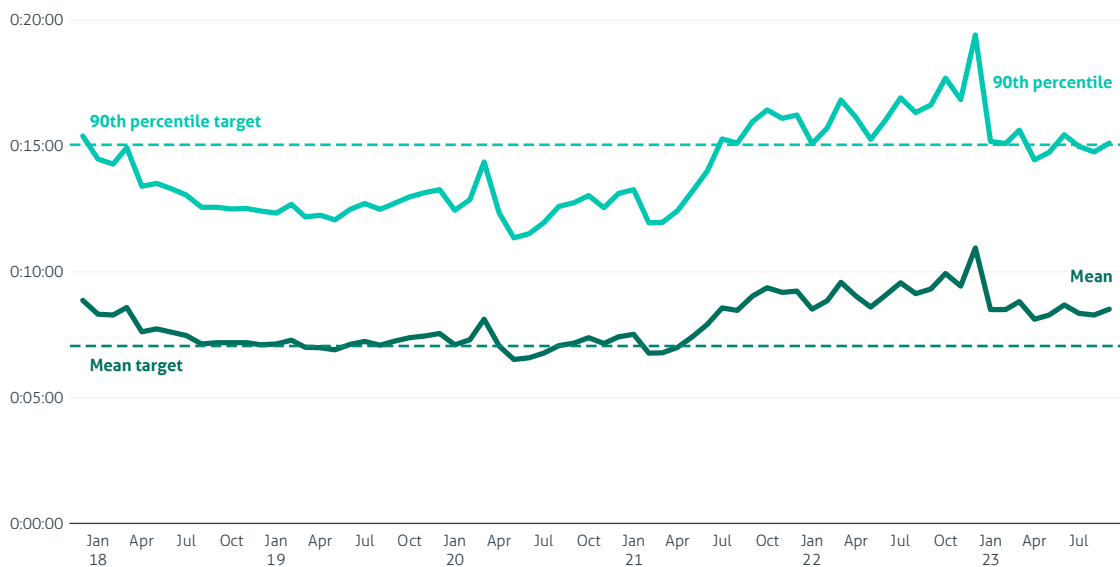
The mean ambulance response time for conditions such as strokes and chest pain (referred to as category 2) in December 2022 was more than 1 hour and 30 minutes, compared to a target of 18 minutes. The mean ambulance response time for the most serious call-outs (referred to as category 1), including life-threatening conditions, also reached a record high of 10 minutes 58 seconds, compared to a target of 7 minutes.

Figure 2.19 **Average response times for category 2 ambulance incidents (hours), December 2017 to September 2023**



Source: Institute for Government analysis of NHS England, 'Ambulance quality indicators' ('Response times' table), September 2023, supported by CIPFA. Notes: The 90th percentile indicates that 90% of response times were faster than this, and 10% were slower. Category 2 responses are for serious conditions, such as a stroke or chest pain, which may require urgent transport. Data before 2017 is not available.

Figure 2.20 **Average response times for category 1 ambulance incidents (minutes), December 2017 to September 2023**

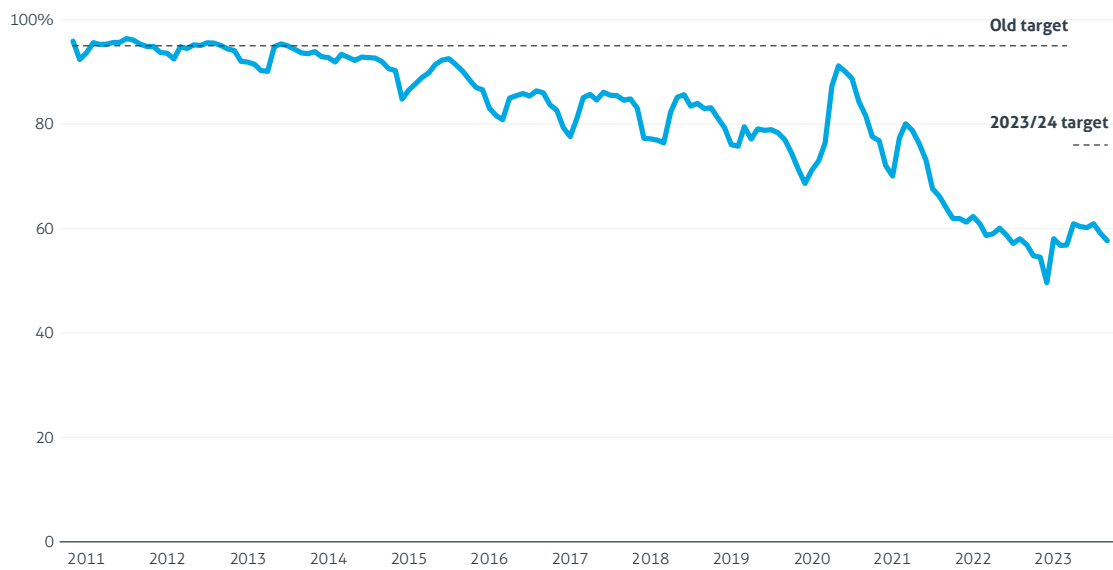


Source: Institute for Government analysis of NHS England, 'Ambulance quality indicators time series' ('Response times' table), September 2023, supported by CIPFA. Notes: The 90th percentile indicates that 90% of response times were faster than this, and 10% were slower. Category 1 responses are for the most severe calls that include a life-threatening condition, such as cardiac or respiratory arrest. Data before 2017 is not available.

In major A&E departments*⁶² the lowest proportion of attendees on record were seen within the targeted four hours, at 49.6% in December 2022. There was only one month in 2022/23 (May 2022) when performance was above 60%. Even then, only 60.1% of people who attended major A&E departments were seen within four hours, compared to a target of 95%.

* These are type-1 A&E departments and are what people typically think of when discussing A&Es and which the NHS defines as A&Es with "a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients".

Figure 2.21 **People seen in major A&Es within four hours, November 2010 to September 2023**



Source: Institute for Government analysis of NHS England, 'A&E attendances and emergency admissions' ('Performance' table), September 2023, supported by CIPFA. Notes: Figures are for waiting times for non-specialty (type 1) A&E departments.

In 2023, the NHS began releasing information on how many people waited for more than 12 hours in A&E. Along with data revealed by a Royal College of Emergency Medicine Freedom of Information request, this shows that 211,720 people (or roughly 15%) waited more than 12 hours in A&Es in December 2022.⁶³ That compares to a target that only 2%.⁶⁴

Figure 2.22 **A&E attendances that result in a 12+ hour wait, January 2018 to September 2023**



Source: Institute for Government analysis of Royal College of Emergency Medicine, 'NHS performance tracker', retrieved 2 October 2023 and NHS England, 'Supplementary ECDS analysis time series' ('Time series' table), September 2023, supported by CIPFA. Notes: Figures before January 2018 are not available. Figures are for waiting times for non-specialty (type 1) A&E departments.

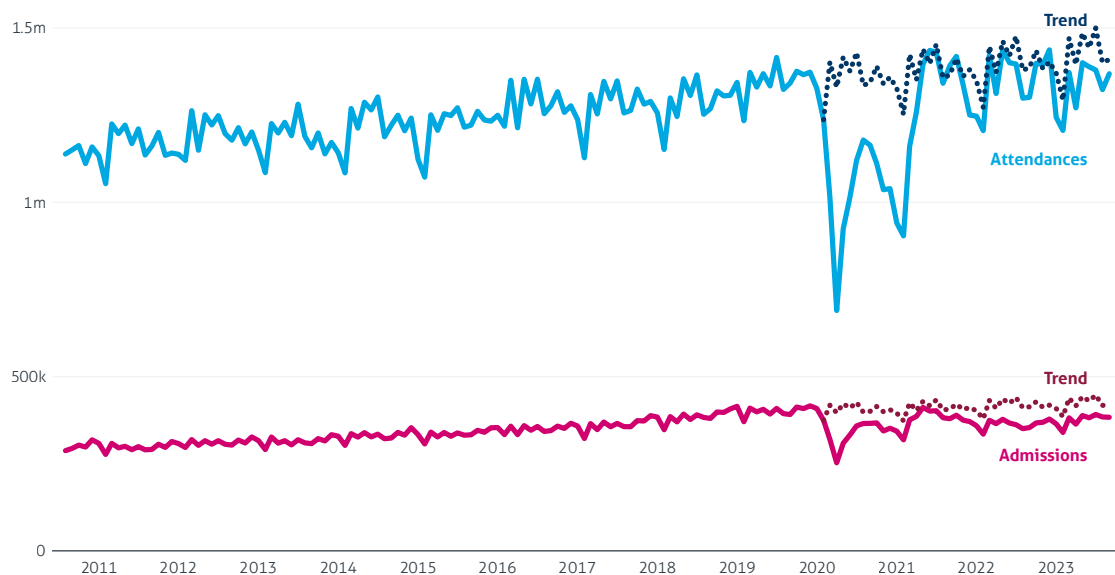
The government responded to this crisis by providing £750m to both the NHS and local authorities to increase capacity in social care, the number of ambulances and the number of beds in hospitals.⁶⁵ The goal was to improve flow through hospitals so the NHS could treat people more quickly.

The efficacy of these interventions is questionable, but it was not helped by the late disbursement of funds, which was itself the result of the government's rushed planning and preparation before winter 2022/23.⁶⁶ Political turmoil exacerbated the poor preparation – this saw four different health secretaries in post between July and October 2022 (though Steve Barclay filled the post twice, once in July and then again in October).⁶⁷ Interviewees reported that this lack of political direction and uncertainty made planning very difficult, as successive secretaries of state rapidly shifted priorities. Liz Truss's health secretary, Thérèse Coffey, launched *Our Plan for Patients* in September 2022,⁶⁸ only to see that document superseded when Rishi Sunak and Barclay outlined their own priorities for the service in the middle of November, weeks before the start of the winter crisis.⁶⁹

Poor patient flow is driving poor performance, not high demand

In targeting the improvement of patient flow through hospitals, the government has identified lengthening waiting times for urgent and emergency care as the cause of poor patient flow. Attendances at major A&Es have increased slowly since the sharp decline at the start of the pandemic and in 2022/23 were 2.5% higher than in 2019/20 – an annual rate of growth of only 0.8%. In contrast, A&E attendances grew at a rate of 1.4% per year between 2011/12 and 2019/20. There were 8.1 million ambulance incidents in 2022/23, 7.6% lower than the 8.8 million in 2019/20.

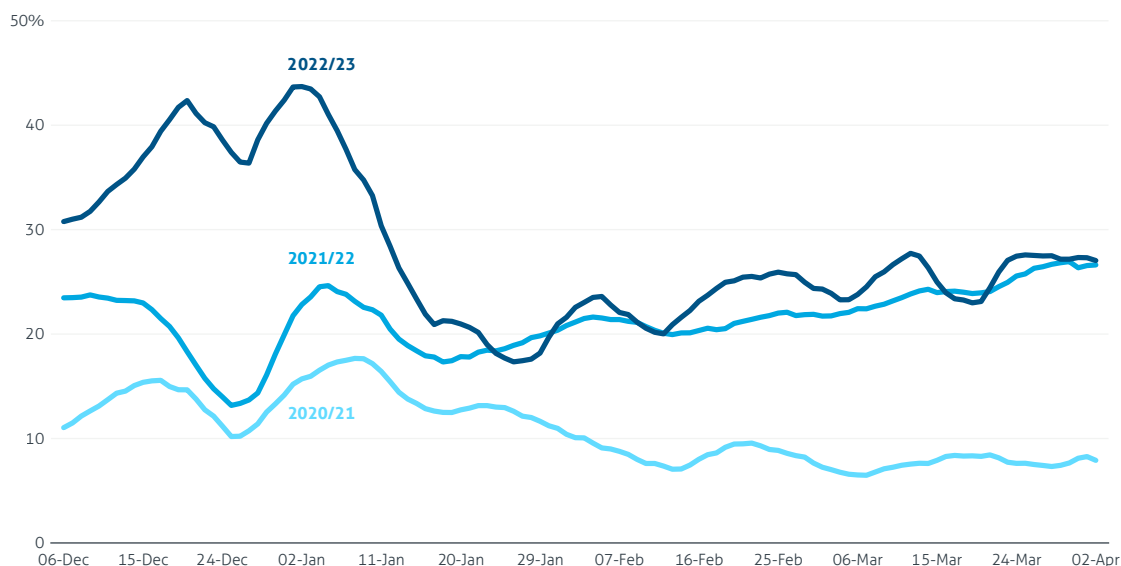
Figure 2.23 **Attendances and admissions in major A&E departments, August 2010 to September 2023**



Source: Institute for Government analysis of NHS England, 'A&E attendances and emergency admissions' ('Activity' table), September 2023, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline. Figures are for waiting times for non-specialty (type 1) A&E departments.

Rather than high demand, the delays that manifest at the front door of hospitals in the form of long A&E waits and ambulance handover delays are mostly caused by poor flow through the hospital and delays discharging people once they are fit, more on which below.*

Figure 2.24 **Ambulance arrivals resulting in a handover delay of 30+ minutes during winter peaks, 2020/21–2022/23**



Source: Institute for Government analysis of NHS England, 'Urgent and emergency care daily situation reports, ambulance collection, 2022-23' ('Ambulance arrivals and delays' table), 2 April 2023, supported by CIPFA. Notes: These lines show a seven-day rolling average to smooth out daily variation. Data is only available between November and early April every year.

Patient flow issues led to queues of ambulances outside hospitals as crews struggled to hand over patients to hospital staff. This led to 37.2% of ambulance arrivals at hospital being delayed for 30 minutes or more in December 2022, up from 20.1% in December 2021 and 13.3% in December 2020.

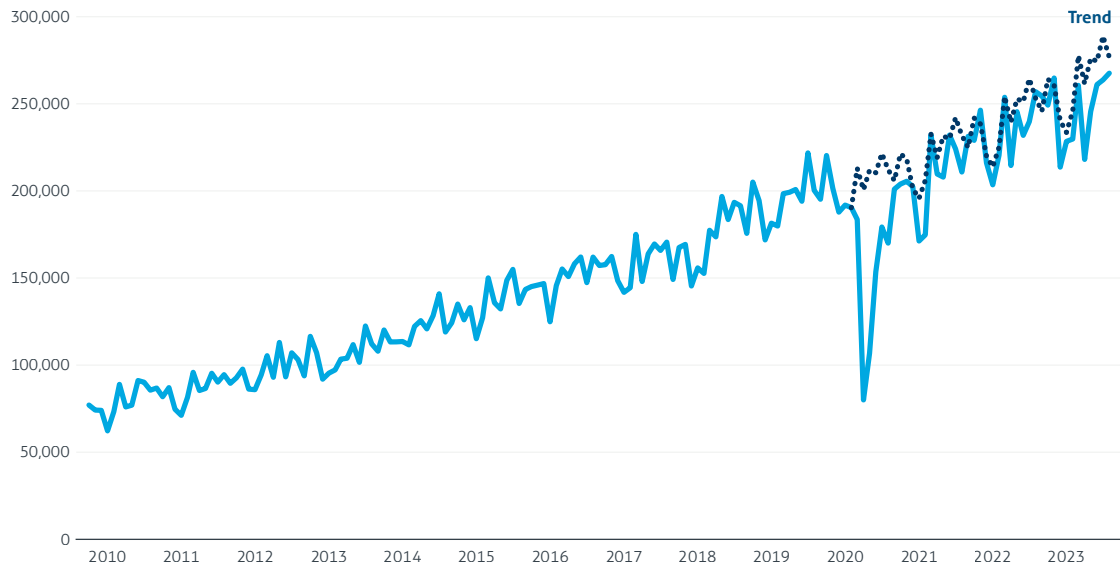
The NHS has been successful in getting people to come forward for cancer treatment

There was a decline in the number of people referred for cancer treatment during the pandemic, raising concerns that many cancers would go untreated. In response, the NHS ran a successful campaign to encourage people to come forward for care.⁷⁰

This resulted in a large increase in the number of cancer appointments following an urgent referral from a GP in 2021/22 and 2022/23. The NHS conducted 2.9 million urgent cancer appointments in 2022/23 compared to 2.4 million in 2019/20 – an increase of 21.1%. Though this is a large increase in activity, it is still roughly in line with the trend rise in the number of appointments over the decade before 2019/20. While impressive, this does imply that some people who might have come forward for care during the pandemic have still not done so.

* Interviewees told us that people are also presenting to A&E departments with more complex cases, but this is very hard to prove with publicly available evidence.

Figure 2.25 Urgent cancer appointments, October 2009 to August 2023

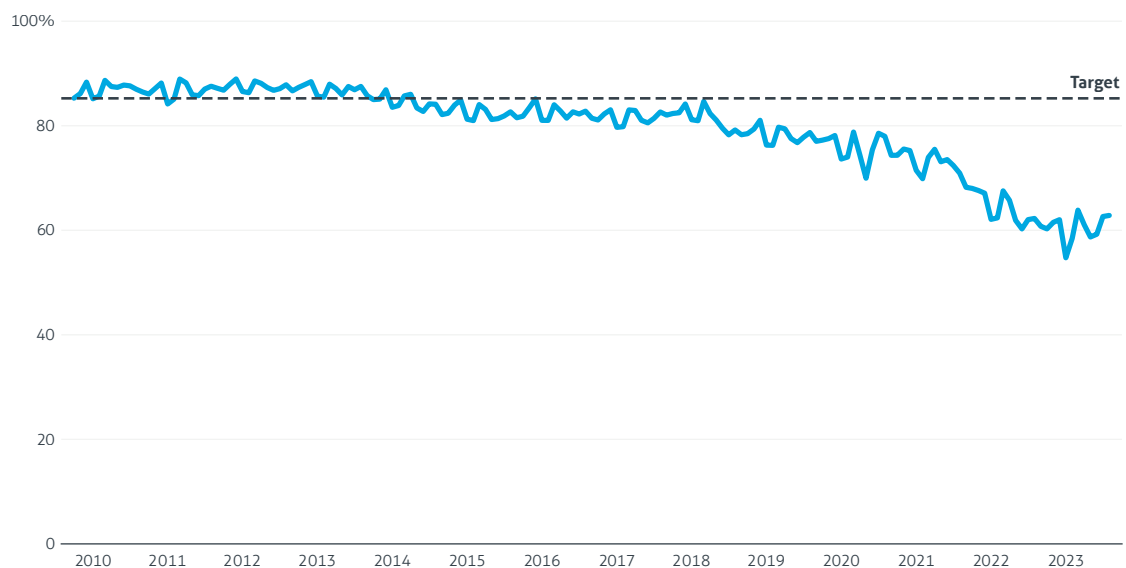


Source: Institute for Government analysis of NHS England, 'Cancer waiting times' ('Monthly data – two week wait from GP urgent' table), August 2023, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline. An appointment is 'urgent' when a GP suspects that a presenting patient may have cancer.

Waits for treatment are still increasing

While more people are coming forward for cancer care, performance against the target that 85% of cancer treatment should start within two months of an urgent cancer referral has deteriorated since the start of the pandemic. That decline against the target could be because more people are now coming forward for care, therefore putting more pressure on the system. But the NHS has also increased capacity for cancer care, with approximately 17% more oncology (cancer care) consultants in July 2023 than in July 2019.

Figure 2.26 Treatment starting within two months of an urgent cancer referral, October 2009 to August 2023



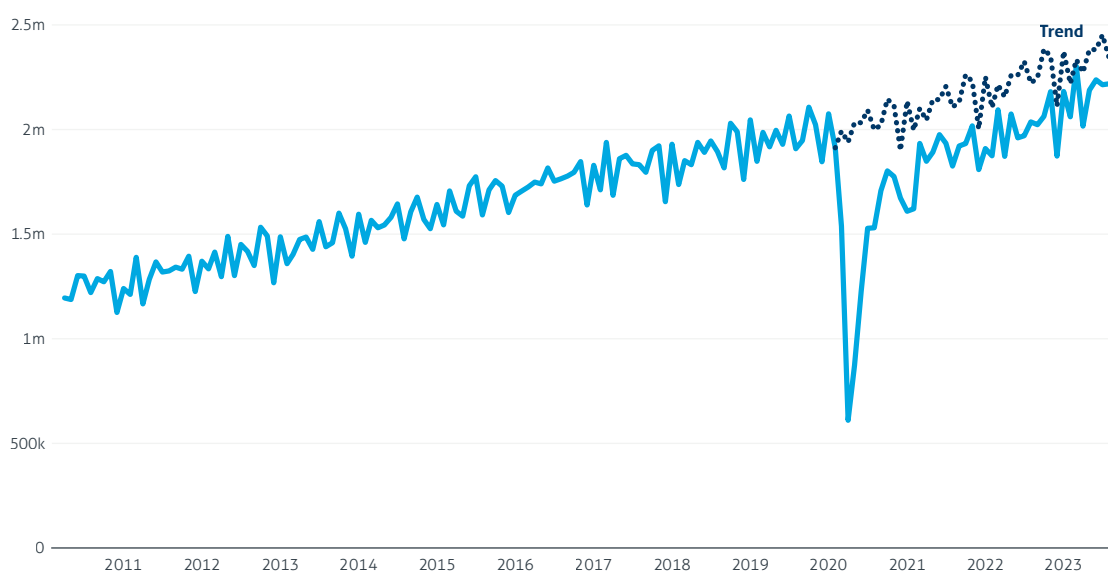
Source: Institute for Government analysis of NHS England, 'Cancer waiting times' ('Monthly data – two month wait from GP urgent referral to a first treatment' table), August 2023, supported by CIPFA.

The year 2022/23 was the worst on record for performance against the 85% target, with only 61.1% of treatments starting within two months of an urgent referral. This compared to 77.2% in 2019/20.

Hospitals are providing more tests than before the pandemic, though are still below trend

Other than cancer appointments, the one major area of hospital activity that delivered more activity in 2022/23 than in 2019/20 was diagnostics. Hospitals carried out 24.4 million diagnostic tests in 2022/23, 5% more than in 2019/20. However, our modelling shows that, if pre-pandemic growth in the number of tests had continued, hospitals would have carried out 2.8 million – or 11.5% – more tests in 2022/23 than they actually did.

Figure 2.27 Hospital diagnostic tests, by length of wait, April 2010 to August 2023



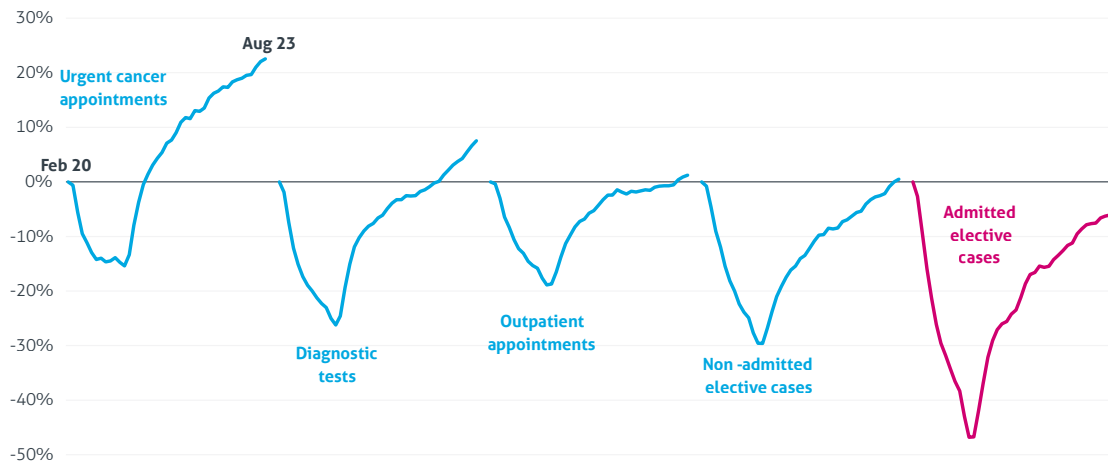
Source: Institute for Government analysis of NHS England, 'Monthly diagnostic waiting times and activity' ('Total activity', '6+ week waits' and '13+ week waits' tables), August 2023, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Having more staff has partly driven the increase in the number of diagnostic tests being carried out – including having 16.8% more diagnostic radiographers in July 2023 than in July 2019. But it is also because the government has taken steps to increase diagnostic capacity, with measures such as community diagnostic centres (CDCs), explored more below.

Cross-cutting contributors to poor hospital performance

Despite more spending on the service and a large increase in the number of nurses and doctors, overall hospital activity has not returned to the level that hospitals achieved directly before the pandemic in a range of key areas.

Figure 2.28 **Hospital activity in the previous 12 months compared to the 12 months to February 2020**



Source: Institute for Government analysis of NHS Digital, 'Monthly hospital episode statistics for admitted patient care and outpatients', August 2023, NHS Digital, 'Monthly diagnostic waiting times and activity' ('Total activity' table), August 2023, NHS England, 'Referral to treatment waiting times', August 2023, and NHS England 'Cancer waiting times' ('Monthly data – two week wait from GP urgent referral' table), April 2023, supported by CIPFA. Notes: Lines show a rolling 12-month average of activity, compared to the 12 months to February 2020, the pre-pandemic baseline.

Given higher spending and staffing levels, this implies that hospitals are now less productive than they were before the pandemic. Previous work from the Institute for Government shows that the reasons for this decline include:

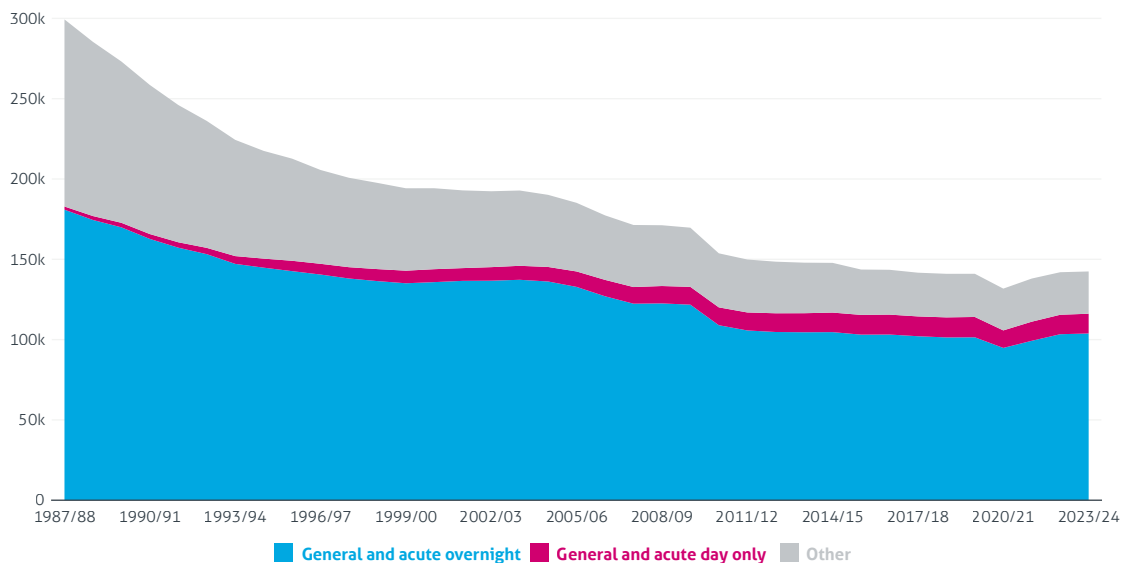
- underinvestment in capital
- a lack of management capacity
- poor retention of experienced staff
- high vacancies at critical points of patient flow
- poorly aligned incentives across the service.⁷¹

Falling bed numbers have contributed to high bed occupancy

The number of beds in hospitals has declined for several decades, though it increased slightly during the pandemic. In 1987/88, there were 182,865 available general and acute (G&A) beds in hospitals.* This fell to 132,841 by 2009/10 and to 114,097 by 2019/20, an overall decline of 37.6%. The number of G&A beds in hospitals increased slightly during the pandemic, and at the end of the first quarter of 2023/24 there were 116,116.

* We discuss G&A beds rather than total beds because they are a better proxy for hospital capacity than the specialised beds included in the non-G&A bed category.

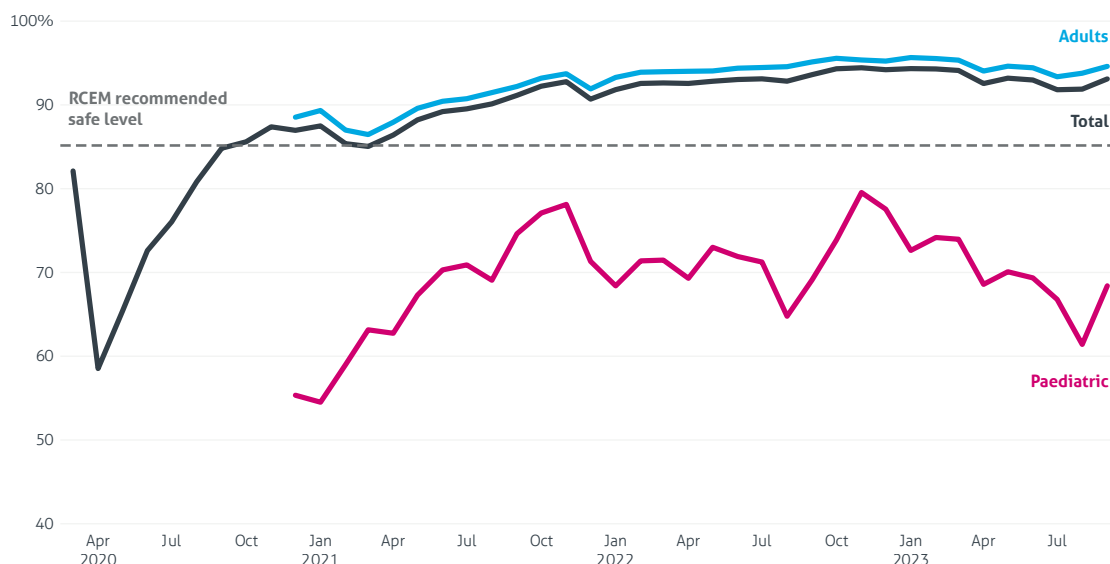
Figure 2.29 NHS beds, 1987/88–2023/24



Source: Institute for Government analysis of NHS England, 'Bed availability and occupancy data' ('Open overnight' and 'Open day only' tables), June 2023, supported by CIPFA. Notes: The figure shows 'available' beds in NHS hospitals. 'Other' is comprised of learning disability, maternity and mental illness beds. 2023/24 shows only the first quarter of data.

Some of the decline in bed numbers is for good reasons: the government wanted to push care out of hospitals and into the community; patients are staying in hospital for a shorter length of time than they used to; and technical progress means that some procedures that previously required a patient to be in hospital can now be done as a day case.⁷²

Figure 2.30 General and acute NHS bed occupancy, March 2020 to September 2023



Source: Institute for Government analysis of NHS England, 'Critical care and general & acute beds – urgent and emergency care daily situation reports' ('Time series type 1 acute trusts' table), September 2023, supported by CIPFA. Notes: RCEM is the Royal College of Emergency Medicine. Data on the split between adult and paediatric G&A beds before December 2020 is not available.

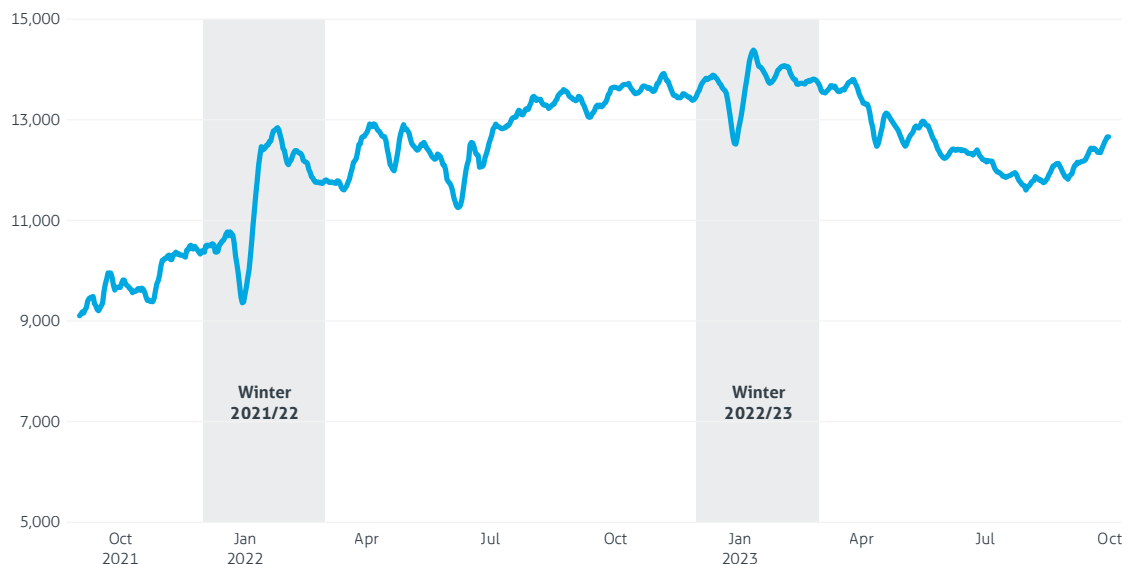
But there is evidence that bed reductions in hospitals went too far before the pandemic, given there was not the increase in community capacity needed to achieve the government's goal of moving care out of hospitals. The NAO recommends that bed occupancy should not exceed 85%, otherwise hospitals may experience "regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections".⁷³ Bed occupancy began to creep up in the early 2010s and, by the middle of the decade, one in six trusts reported occupancy levels above 95%.⁷⁴ There was a dip in occupancy at the start of the pandemic, as the NHS urgently discharged patients, but that trend quickly reversed and G&A occupancy has been above 85% since October 2020. Adult G&A occupancy was above 95% between September 2022 and March 2023. While there was a slight dip during the summer months, it returned to 94.6% in September 2023. The NHS has a target for 2023/24 to reduce adult G&A bed occupancy to 92%.⁷⁵

As part of its *Delivery Plan for Recovering Urgent and Emergency Care Services*, published in January 2023, the government aimed to have "5,000 more staffed, sustainable beds in 2023/24" compared to the "originally planned levels of beds in 2022/23".⁷⁶ It is difficult to fully evaluate this pledge as there is no information about what the "originally planned levels" were in 2022/23. But regardless, there were 2,714 fewer G&A beds in the largest acute trusts in September 2023 than January 2023,⁷⁷ when the delivery plan was launched.

Delayed discharge is slowing patient flow

One of the key reasons for slow patient flow is the difficulty that hospitals have in discharging patients in a timely manner.

Figure 2.31 **Delayed discharge from hospitals, September 2021 to September 2023**



Source: Institute for Government analysis of NHS England, 'Acute daily discharge situation report – time series: April 2021 to September 2023' ('Daily series' table), supported by CIPFA. Notes: 'Delayed discharge' refers to people who no longer meet the criteria to remain in hospital at the end of the day. 'Winter' here starts on 1 December and ends on 28 February each year. This shows a seven-day rolling average.

Between 1 December 2022 and 28 February 2023, an average of 13,571 people were in hospital beds at the end of the day who were eligible for discharge. That is approximately 14% of G&A beds in hospitals.

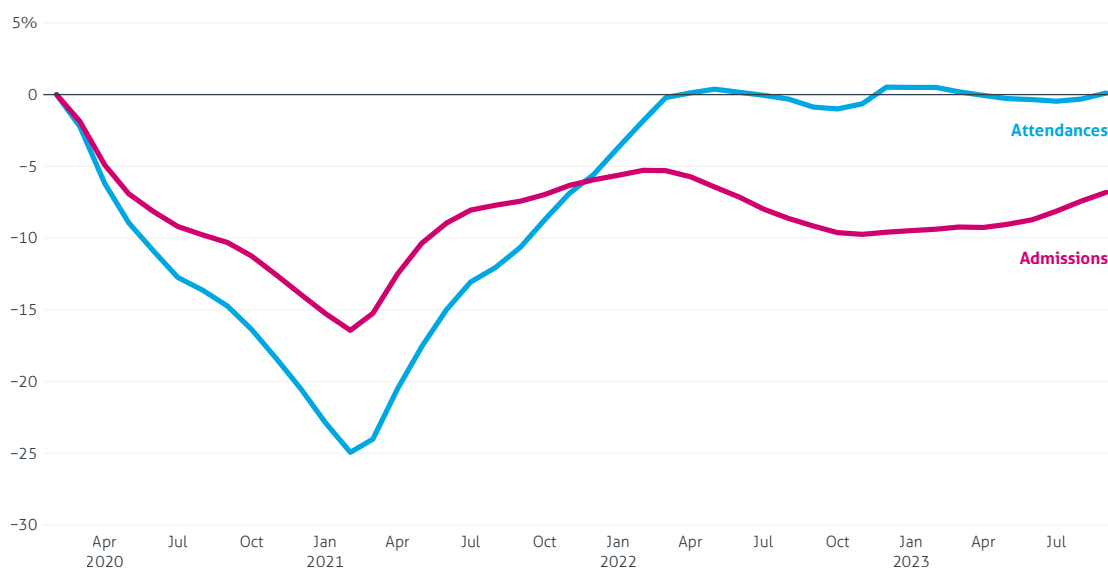
The causes of delayed discharge are complex and, following the government's decision to stop publishing reasons for delayed discharge between February 2020 and May 2023, difficult to attribute to specific causes. The decision to start publishing some data again from June 2023 is very welcome.⁷⁸ The press and the government have mostly laid the blame for delayed discharge on a lack of capacity in adult social care. However, work from the Nuffield Trust shows that social care accounts for less than half of delayed discharge, with the remaining proportion accounted for by reasons within the NHS,⁷⁹ such as the lack of a discharge summary, no transport to convey someone home or a delay in issuing prescriptions.⁸⁰

As discussed above, the government provided additional funding to address delayed discharges, but this was not as impactful as it might have been.

Poor flow makes it difficult to increase activity

High bed occupancy and the resultant reduction in patient flow have affected hospital activity. Despite more or less similar level of attendances (0.1% more) at the largest A&Es in the 12 months to September compared to the 12 months to February 2020, there were 6.8% fewer admissions. There are a few potential reasons for this change. The Health Foundation hypothesises that high bed occupancy – among other reasons – meant that “hospitals were forced to change admission thresholds – ie not admitting some patients for shorter admissions who would have been admitted in 2019”.⁸¹ Increased admission thresholds during periods of high bed occupancy is a phenomenon that has been observed before. One study found that “a patient attending [an emergency department] during a period of very high... occupancy was 3.3% less likely... to be admitted” when compared with periods of average occupancy.⁸²

Figure 2.32 **Attendances and admissions at major A&E departments in the previous 12 months compared to the 12 months to February 2020**



Source: Institute for Government analysis of NHS England, 'A&E attendances and emergency admissions' ('Activity' table), September 2023, supported by CIPFA. Notes: These lines show a rolling 12-month total compared to 2019/20. Figures are for waiting times for non-specialty (type 1) A&E departments.

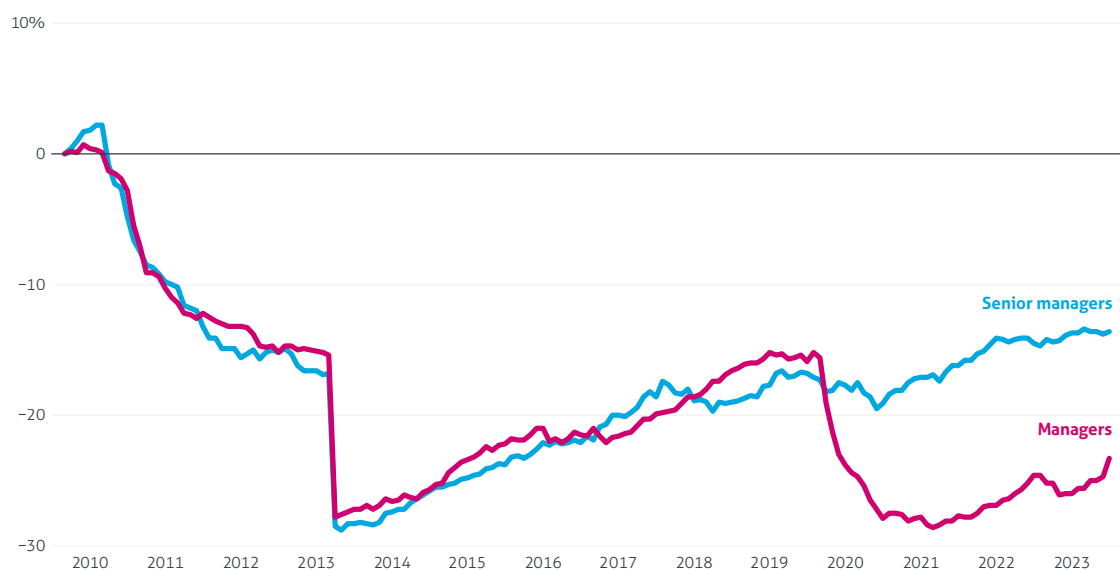
It could also be the case that hospitals are treating patients with less severe conditions in different ways now than they were before the pandemic. For example, the NHS has extended the use of 'virtual wards'⁸³ – which allows patients to receive treatment at home, and is discussed in more detail below. The NHS is also increasing the use of what is known as 'same day emergency care' (SDEC) centres,⁸⁴ which are designed to allow patients to access care that may have previously required a short admission.⁸⁵ In both these cases, the interventions are relatively new and have been rolled out across the country in an inconsistent manner. It is therefore difficult to fully attribute such a large national reduction in admissions to these changes.

It is still unclear what effect the reduction in admissions has on the quality of care that people receive when they attend A&Es. There could also be implications for the wider health and care system; people who are not treated at an A&E department when they once might have been may seek care somewhere else, adding to pressure on those services.

The ratio of managers to staff is lower than before the pandemic

One of the most maligned staff groups in the health service is managers. They are commonly attacked in the press and by MPs,⁸⁶ normally framed as taking resources away from the 'front line'. But the reality is that the NHS has a severe lack of managers. The number of managers in July 2023 was only 2.9% higher than in September 2009, following deep cuts in the first half of the last decade. In the same time period, the number of nurses and doctors grew by more than 30% and 40% respectively. As a result of the rising number of other staff, the number of FTE NHS staff for every manager and senior manager grew from 26.7 to 33.4 over this period – an increase of 25.3%. It should be noted that the number of official managers in the NHS does not include other staff – such as doctors and nurses – who often also take on a management role.

Figure 2.33 **Change in the number of managers per FTE NHS staff member since September 2009**



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics, England and organisation' ('1. England' table), July 2023, supported by CIPFA. Notes: Both manager and total NHS staff numbers are in terms of FTE staff.

The NHS is undermanaged compared to the rest of the economy. Only 3.0% of the NHS workforce were managers or senior managers in July 2023, down from 3.7% in September 2009. In comparison, across the entire economy, approximately 11% of staff are employed in management roles.⁸⁷ While clinicians and nurses are certainly carrying out some management tasks, there is a severe lack of administrative capacity that dedicated managers would be able to meet.⁸⁸

This lack of management hampers the productivity of front-line staff; there are fewer people to co-ordinate where and how staff should be working to be most effective, to book and manage elective appointments⁸⁹ or to identify bottlenecks in patient flow. Managers also do administrative work that, if they do not do it, often falls to front-line staff. At higher levels of seniority, managers can co-ordinate resources across many constituent organisations – for example, trusts or ICSs – to improve efficiency.⁹⁰ But on one visit to a trust, we saw that a lack of more junior management capacity meant that senior managers in the trust were often carrying out operational planning, rather than the more strategic work that they are arguably best placed to deliver. Increasing the numbers of managers (up to a point) helps to improve patient outcomes and patient satisfaction.⁹¹

Even when there is management capacity, the NHS often does not provide managers with enough autonomy to carry out their work effectively. Institute for Government work from earlier in the year shows that this has been happening in a number of ways. First, there has been increasing centralisation of NHS decision making over the past decade and a half.⁹² For example, the Blair government introduced foundation trusts as a way of giving top-performing NHS trusts more autonomy over spending and decision making.⁹³ But the power of foundation trusts has been gradually eroded,⁹⁴ and the Health and Care Act 2022 allowed the DHSC to impose capital spending limits on foundation trusts.⁹⁵ Centralisation has advantages and disadvantages, but there is evidence that it prevents managers from making effective decisions about how to, for example, spend their capital budgets.⁹⁶

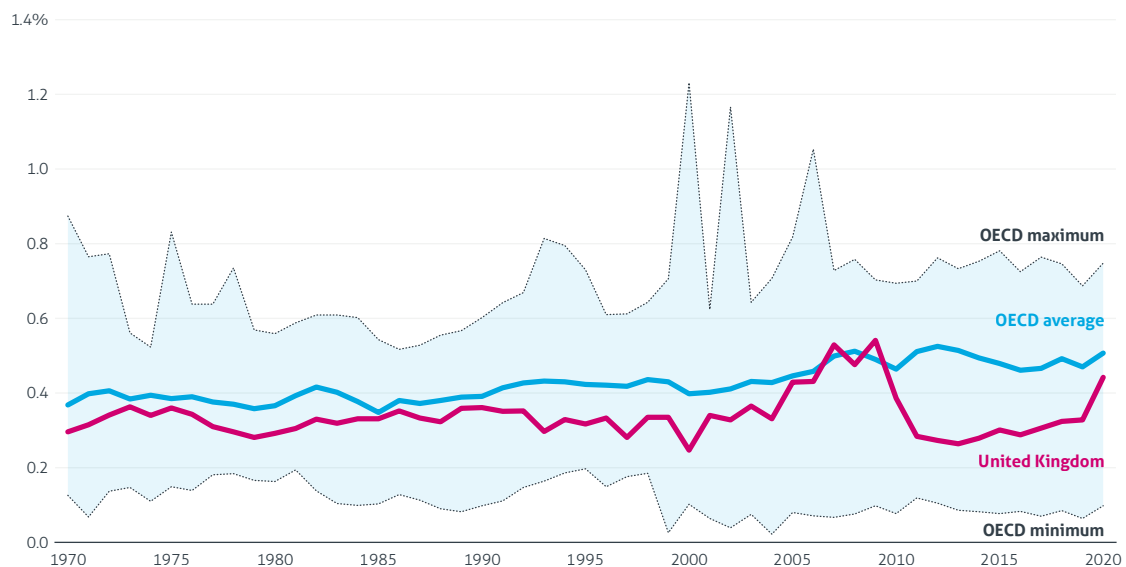
Second, there has been a proliferation of targets from the centre of government with which trusts have to comply.⁹⁷ The need to do so means that managers are drawn away from work that could help improve productivity, and instead they focus on meeting targets that sometimes have little to do with improving outcomes.

Underinvestment in capital

The UK has consistently spent less on health-related capital* – investment in buildings, maintenance of the estate, equipment in hospitals and IT systems, among other things – than many other countries in the Organisation for Economic Co-operation and Development (OECD). Since 1970, the UK only exceeded the weighted OECD average in two years: 2007 and 2009.⁹⁸ Between 1970 and 2010, the UK spent 84.3% of the OECD average on health capital. This fell to 62.5% in the years between 2011 and 2020.

* We use data on the entire health system here rather than hospitals because comparable OECD data is only available at a health system level.

Figure 2.34 **Gross capital formation in health care as a percentage of GDP, by OECD country, 1970–2020**



Source: Institute for Government analysis of OECD, 'Gross fixed capital formation in the health care system', 2022 and OECD, 'Gross domestic product (GDP)', 2022. Notes: The average is weighted by the size of the country's GDP. When a country has no data for a particular year, it is excluded from the analysis. The year 2020 is the last one for which the UK has data. Adapted from Health Foundation analysis.

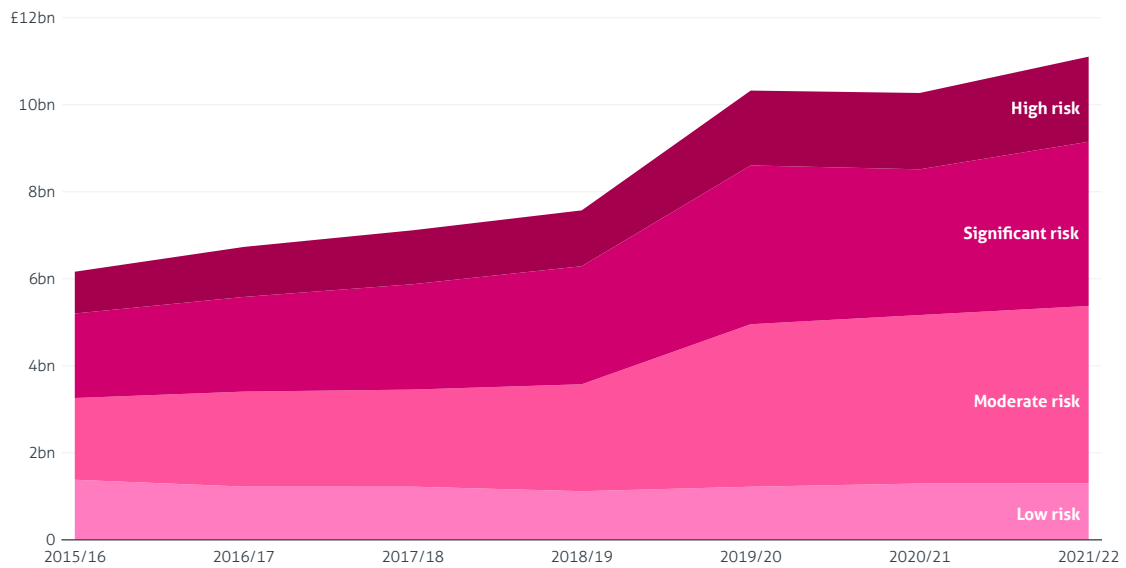
Even within the context of longer-term underinvestment, the 2010s was a period of very low capital spending in the health service. The average amount spent on capital in health care was 0.41% of GDP between 2000 and 2009. This fell to 0.30% between 2010 and 2019 – a reduction of more than 26%.

Historic underinvestment in capital is hindering hospital productivity

The effect of underinvestment in the health service is difficult to fully quantify, though there are some indicators that point to the drag that it is having on staff's ability to do their jobs.

The hospital estate maintenance backlog – the amount of money needed to return the NHS estate to full working order – rose to the highest level on record in 2021/22: £10.2bn. The proportion of the backlog that is classified as 'high risk' – where repairs must be carried out urgently to prevent "catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution"⁹⁹ – is also the highest on record at 17.6%. This backlog limits the ability of staff to carry out their work effectively. It can mean, for example, that parts of hospitals are closed due to sewage leaks.¹⁰⁰

Figure 2.35 **Cost to eradicate the hospital maintenance backlog, by severity, 2015/16–2021/22 (2023/24 prices)**



Source: Institute for Government analysis of NHS Digital, 'Estates Returns Information Collection – dataset for ERIC 2021/22, report version 2' ('Table 10'), supported by CIPFA. Notes: Data is only available from 2015/16.

It is not just the estate that the NHS has underinvested in, but also IT systems and equipment. The NHS has many fewer CT (computerised tomography) scanners and MRI (magnetic resonance imaging) machines in hospitals than comparable countries in the OECD, at only 10.02 and 8.57 per one million people respectively. In comparison, Spain has 19.23 and 15.86 and Germany has 19.54 and 13.14 respectively. This lack of equipment acts as a bottleneck for diagnostic tests in hospitals, which prevents increased elective and other activity.

Table 2.1 Hospital diagnostic equipment per million population, by OECD country, 2021

	CT scanners	MRI scanners
OECD average	20.1	13.8
South Korea	32.3	29.6
Italy	28.0	20.1
United States	27.0	17.9
Sweden	23.0	17.2
Luxembourg	21.9	17.2
Germany	19.5	13.1
Spain	19.2	15.9
Estonia	18.8	12.8
Austria	17.5	12.0
Poland	17.3	6.7
Greece	17.0	8.0
Finland	17.0	31.2
Czech Republic	15.2	9.7
France	11.2	7.1
United Kingdom	10.0	8.6
Israel	8.2	4.6
Mexico	7.3	2.9
Costa Rica	3.3	0.4

Source: Institute for Government analysis of OECD, 'Computed tomography (CT) scanners', 2022 and OECD, 'Magnetic resonance imaging (MRI) units', 2022, supported by CIPFA. Notes: 2021 is used as the year of comparison because it is the most recent year for which there is data for the UK. 'Diagnostic equipment' relates to CT and MRI scanners. This table excludes OECD countries that do not have data for both categories.

The government's major capital project for hospitals is the New Hospital Programme (NHP), which follows from a Conservative manifesto commitment to build 40 new hospitals by 2030.¹⁰¹ In 2020, the DHSC announced 32 hospitals that it would build under this scheme (with a further eight to be announced) and the 2020 spending round allocated £3.7bn worth of funding for the programme in the four years between 2021/22 and 2024/25.¹⁰² This represents approximately 8% of the DHSC's capital budget for that period.¹⁰³ In May 2023, the government announced that it was going to delay the building of eight hospitals that it originally intended to build as part of the NHP and instead rebuild five hospitals that are currently built mostly of reinforced autoclaved aerated concrete (RAAC)¹⁰⁴ – a material that caused the unexpected and sudden collapse of a school in Kent in 2018.¹⁰⁵

But the NAO has raised doubts about the veracity of the government's claim that the NHP will build 40 new hospitals. In its report from July 2023, it said that "by the definition used in 2020, [the] NHP will no longer construct 40 new hospitals by 2030".¹⁰⁶ It also says that of the 32 hospitals announced in October 2020, only 11 (34%) "represented whole new hospitals".¹⁰⁷ The rest are rebuilds of existing hospitals, new buildings at existing sites or major refurbishments of existing hospital buildings.¹⁰⁸

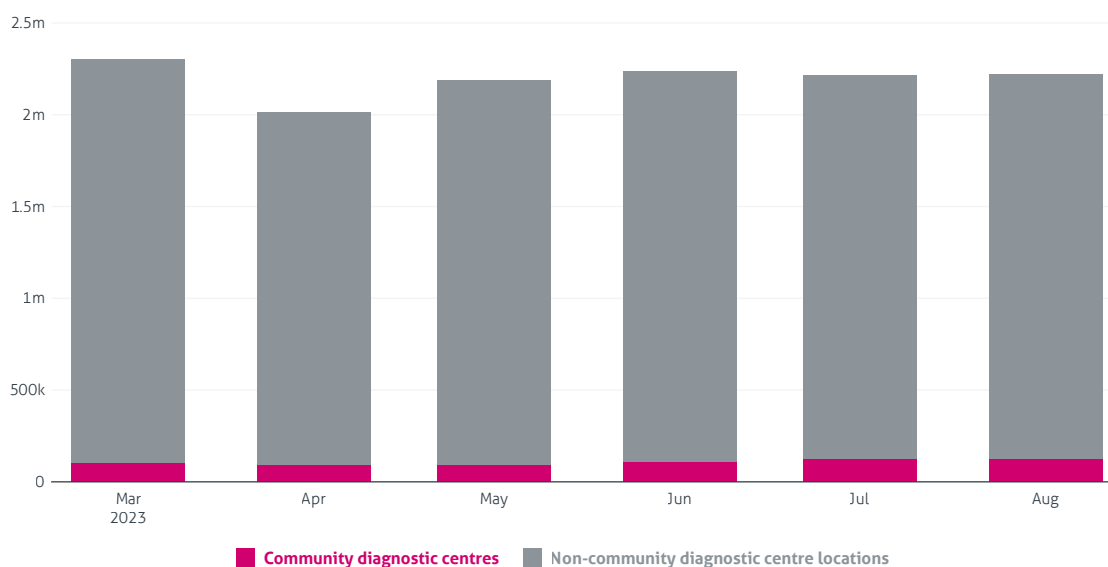
Some of the government's interventions are helping to improve hospital performance

Community diagnostic centres (CDCs)

One of the government's primary interventions to work through the elective backlog was the introduction of community diagnostic centres (CDCs). These were intended both to increase diagnostic capacity and to put diagnostic capability closer to those who require it.¹⁰⁹ As of 14 August 2023, there were 108 CDCs across England, with plans to reach a total of 160 by March 2025.¹¹⁰

The launch of CDCs does seem to have helped the number of diagnostic tests that the NHS carries out return to 2019/20 levels (as discussed above), but this is difficult to assess due to the lack of data. Despite CDCs being operational since July 2021, the NHS only started publishing activity data in March 2023. This data shows that 4.7% of diagnostic tests carried out in England took place in CDCs in March, April and May 2023.

Figure 2.36 **Diagnostic tests conducted, March to August 2023**



Source: Institute for Government analysis of NHS England, 'Monthly diagnostic waiting times and activity' ('Total activity' table), August 2023 and NHS England, 'Monthly diagnostics for community diagnostic centres', ('Provider (CDC)' table), August 2023, supported by CIPFA. Notes: CDCs have only been in existence since 2021 and data about their activity has only been publicly available since March 2023.

However, it is unclear whether all this activity is truly additional. According to research by The King's Fund, 47 of the 92 CDCs that were open at the time of the research had been built on existing hospital sites,¹¹¹ raising questions of whether they are truly moving diagnostic capacity into the community, as the government intended.¹¹² There is also the question of staffing. Hospitals often find it difficult to staff their existing diagnostic departments, let alone provide staff for CDCs.¹¹³ If it is staff that is the limiting factor on expanding diagnostic capacity, then opening CDCs will do little to help, other than displace activity from one area to another. But despite these issues, interviewees told us that, on balance, they felt that a good proportion of CDC activity is additional, although they were unable to quantify how much.

This data also does not capture all CDC activity. CDCs also carry out tests – for example, a number of blood tests – that are not tracked as part of the NHS’s diagnostic dataset that we use to inform our analysis.

Surgical hubs

Surgical hubs are areas of a hospital – either in addition to the current estate or by reallocating part of the existing estate – that are dedicated to carrying out elective procedures.¹¹⁴ These hubs are intended to work through high-volume, low-complexity procedures¹¹⁵ such as cataract removal. The government has to date opened “around 93 hub sites”,¹¹⁶ and estimated in August 2022 that these hubs would carry out 200,000 procedures in 2022/23¹¹⁷ – an amount that would represent 1.2% of completed elective procedures in that year.

As with CDCs, it is difficult to fully evaluate the effectiveness of elective hubs, especially as the NHS does not publish data about their activity. Interviewees told us that there is a real benefit to trusts creating elective hubs on existing sites.¹¹⁸ This is because it attracts additional investment and allows for better separation of emergency and elective activity – a step that ensures that elective activity continues even when there is a spike in demand for emergency care. However, the lack of certain staff groups in elective hubs – particularly anaesthetists and theatre nurses – which is the result of shortages across the NHS, limits their ability to provide additional activity.¹¹⁹

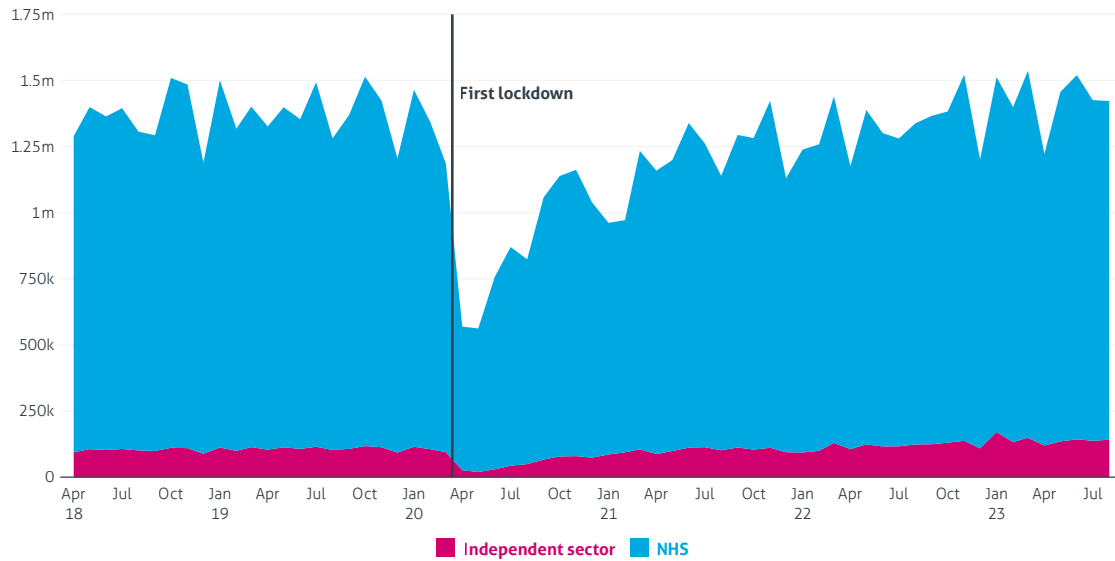
Advice and guidance (A&G)

Increased use of advice and guidance (A&G) – where a GP consults with a secondary care colleague before making a referral – seems to be keeping people out of hospitals who do not need to be there (for more information on A&G, please see the GPs chapter). The NHS claims that A&G is diverting approximately 130,000 unnecessary referrals a month. However, there is little information about the outcomes for those diverted away from elective care, who would previously have attended hospital. It is certainly better for patients who do not need to go to hospital to avoid a visit, but it is still unclear if there are any people who are diverted due to A&G but who would have benefited from joining the elective waiting list.

Use of the independent sector

The NHS elective recovery plan and the subsequent elective recovery taskforce¹²⁰ both included plans to make greater use of independent sector providers (ISPs) to increase elective activity – a policy that the NHS has been pursuing since at least the early 2000s.¹²¹ This has proved to be moderately effective. Compared to 2019/20, ISPs carried out 23.8% more elective procedures in 2022/23. In comparison, NHS providers conducted 2.2% fewer procedures.

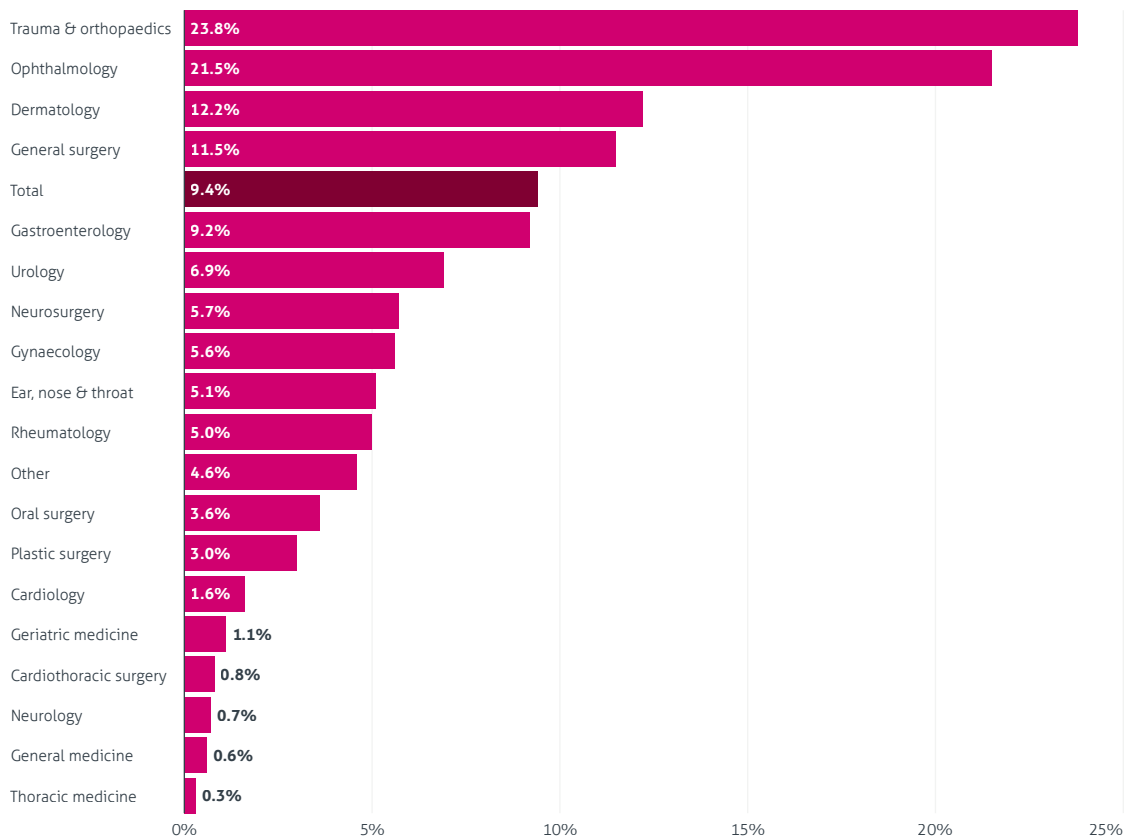
Figure 2.37 **Elective procedures, by provider, April 2018 to August 2023**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Admitted provider' and 'Non-admitted provider' tables), August 2023, supported by CIPFA.

While the increase of ISP activity has been large, it is from a relatively small base and the vast majority of elective activity is still carried out in NHS providers. ISPs are best suited to providing very specific types of activity, namely high-volume, low-complexity work. In 2022/23, ISPs carried out 23.8% of trauma and orthopaedic procedures and 21.5% of ophthalmology – mostly cataract removal¹²² – procedures, both of which fit the description of specialties with high volume, but low complexity.¹²³

Figure 2.38 **Procedures conducted by independent providers, by specialty, 2022/23**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Admitted provider' and 'Non-admitted provider' tables), April 2022 to March 2023, supported by CIPFA.

But there is a limit to the extent to which ISPs can support elective activity. The vast majority of more complex elective work will continue to be conducted within the NHS for the foreseeable future.¹²⁴ For example, only 0.3% and 0.7% respectively of thoracic and neurology procedures were carried out in ISPs in 2022/23, due to their relative complexity. ISPs also compete with the NHS for staff, meaning that it is difficult to expand capacity without reducing the NHS's ability to deliver elective activity.¹²⁵ Work by The Health Foundation also shows that those living in more affluent parts of England use ISP-delivered elective care more than those in the most deprived parts of the country.¹²⁶ If the expansion of ISP capacity follows existing distributions, then those in more affluent areas will benefit the most. Finally, in a report examining the efficacy of different approaches to reducing the elective waiting list, The King's Fund concluded that there is "little empirical evidence that the additional capacity provided/activity undertaken by the private sector in England from 2003 to 2008 contributed to the rate at which waiting times were reduced".¹²⁷

Virtual wards require longer to reach their full potential

During the pandemic, to reduce in-person contact, the NHS greatly expanded the use of so-called 'virtual wards', where a hospital provides a patient with monitoring equipment so that they can stay in their own home rather than occupying a hospital bed; remaining at home is often preferable to a hospital stay. Hospitals have used this as a way of expanding capacity without investing in physical beds. The NHS has an ambition to create "40-50 virtual beds per 100,000 population";¹²⁸ meaning a total of approximately 22,400–28,000 virtual ward beds in England. Data from NHS England shows that the government hit its target¹²⁹ to have 10,000 virtual ward beds operational by September 2023, with 10,421 opened.¹³⁰ Of those 10,421 virtual ward beds, only 65.3% were occupied in September.¹³¹ Given bed occupancy levels in the rest of the health service are close to 95%, this raises questions as to why there is so little uptake of the available virtual ward capacity.

Work by The Health Foundation shows that 63% of NHS staff are 'very' or 'quite' supportive of the use of virtual wards.¹³² And a report from the NHS Confederation claims that: "When done well the model is seen as a successful way to keep people out of hospital, discharge early to home, reduce clinical time and give patients autonomy and choice in their own surroundings."¹³³

But there are still barriers to effective implementation. The NHS needs to upskill staff to maximise the effectiveness of virtual wards, as well as employ enough health care workers to properly staff them. The report from the NHS Confederation mentioned above also calls for flexibility in how the model is applied locally, with less prescription from the centre of government. Respondents also highlighted the importance of senior clinician buy-in for virtual wards, something that is currently frequently lacking due to concerns about the risks of managing patients remotely.¹³⁴ Some of that concern from older doctors may be due to an aversion to new methods. But some of it may be warranted. There is still little evidence about the efficacy of virtual wards or the effect on patient outcomes – work that the NHS should prioritise if it plans to continue the expanded use of virtual wards.

Government's cuts to integrated care systems' budgets will prevent them working effectively

One of the Johnson government's flagship pieces of NHS reform was the creation of integrated care systems (ICSs), which were intended to improve the co-ordination and co-operation of a fragmented health and social care system. ICSs bring together representatives from acute trusts, primary care, local authorities (which are responsible for commissioning adult social care) and some social care providers.¹³⁵ The government put ICSs on a statutory footing in July 2022, leading to the creation of 42 of them across England.¹³⁶

ICSs faced a difficult first year, dealing with arguably the most severe winter crisis in the health service's history. Despite that, ICSs were beginning to embed themselves into their local health and care ecosystems and were creating initiatives to deliver more integrated care. One interviewee told us that they created teams for major conditions that worked across a range of primary care, secondary care, community care and social care.¹³⁷ But it is difficult to give a full picture of all ICSs' activity from a small number of interviews due to wide variation in the initiatives ICSs are implementing and the progress they have made.

In March 2022, the government told ICSs that they would need to cut 30% of their management spending in 2023/24.¹³⁸ These cuts will require a reduction in the staffing of integrated care boards¹³⁹ and interviews revealed that it has hurt the morale of at least some ICS staff and contributed to people leaving their roles. One interviewee told us that the funding cuts and the changes that accompanied them had taken up all the attention of leadership within their ICS, meaning that the transformation programmes they had started were either delayed or scrapped entirely.¹⁴⁰

The workforce plan is welcome but does not address key issues

The government committed to releasing a long-term workforce plan at the 2022 autumn statement. That plan was released at the end of June 2023.¹⁴¹ The plan sets out an ambition to increase training places for doctors and nurses and outlines new routes to becoming a doctor. There is also an ambition to recruit more staff from within the UK.

It is certainly welcome that the government has supported the NHS to deliver a workforce plan, but laying out an ambition for the size of the workforce is not the same as delivering the plan and there remain risks to successful implementation.

First, the expansion of training places represents an enormous and ambitious shift in higher education. The Health Foundation estimates that if the government sticks to the plan, then clinical health professionals will account for one in six of all university enrolments by 2031/32, compared to one in nine now.¹⁴² The Health Foundation points out that supporting those students with sufficient good-quality clinical placements is crucial for effective training, but that there is currently a lack of capacity. It notes that implementing the plan "will require sustained discussion and action on the part of government, NHS England, NHS providers and universities".¹⁴³

Second, the plan assumes that staff productivity will increase by 1.5% to 2% per year.¹⁴⁴ This is optimistic given that real-terms output per hour in the health sector* – a proxy for NHS labour productivity – was completely flat between 1997 and 2019.¹⁴⁵ The plan acknowledges that “boost[ing] labour productivity will require sustained investment in the NHS infrastructure, a significant increase in funding for technology and innovation”.¹⁴⁶ But as this chapter has shown, the government has historically underinvested in capital, raising doubts about the likelihood of a step change in capital investment to meet this requirement.

Third, the plan focuses predominantly on front-line staff, without any mention of administrative, management and support staff. The plan itself acknowledges that, in addition to more capital investment, achieving the plan’s productivity ambition of 1.5% to 2% would require “reducing the administrative burden on clinicians”.¹⁴⁷ That is certainly a view with which the Institute for Government agrees, but the NHS has repeatedly shifted resources away from management and administrative capacity, as this chapter has pointed out.

Fourth, the rapid expansion of the workforce implies an increase in the wage bill, and therefore spending on the health service. The IFS estimates that implementing the workforce plan would require the government to increase funding for the NHS by 3.6% per year in real terms for the duration of the plan.¹⁴⁸ The IFS points out that this would bring annual rises in line with historic average increases, but would be well above the 2.4% average since 2009/10.¹⁴⁹ The government currently has plans for 1% real-terms increases in day-to-day spending across all departments between 2024/25 and 2027/28. The government could certainly choose to increase spending on the health service by 3.6% per year in that time, but as we argue elsewhere in the ‘Cross-service analysis’ chapter of this report, it would require difficult choices about spending elsewhere.

Overall, the plan is a good starting point and lays out a strong aspiration for how the government would like to staff the NHS, but faces a number of risks to its successful implementation.

* While not a perfect match for hospital productivity, it is the closest proxy that is publicly available.

3. Adult social care



Adult social care: key figures

- **9.5%** – the forecasted real-terms rise in spending in 2023/24 compared to 2022/23 – the biggest increase since at least 2009/10.
- **1 in 10** – the proportion of posts in the adult social care workforce that were vacant in 2022/23.
- **40,416** – the number of visas granted to care workers and home carers in 2022/23, up from 113 in 2021/22.
- **10.6%** – the additional number of people who requested care in 2022/23 compared to 2015/16.
- **-4.6%** – the number of people who received long-term care in 2022/23 compared to 2015/16.

Introduction

The government has acknowledged that the availability of publicly funded adult social care* has not been sufficient to meet people's needs for care and support. It provided a large injection of funding in the autumn statement in 2022 and subsequently. But the adult social care sector faces extensive challenges, including an ongoing workforce crisis, rising costs of providing services and pressure on local authority finances – meaning that even the new level of funding is unlikely to be enough to substantially increase service provision to address the rising levels of unmet and under-met need that have emerged since 2009/10.

Boris Johnson promised to fix adult social care “once and for all”¹ and announced reforms to both the charging model for adult social care and to the wider sector. But the government has abandoned the implementation of charging reforms in this parliament and substantially pared back funding for other reforms. The former decision may have been understandable in the short term, as implementing large-scale charging reforms while adult social care is in crisis would have required far more money than the government was willing to spend. But delay means that it is now more than 11 years since the government-commissioned Dilnot review first recommended a reform to how care is funded, without any meaningful progress having been made.

* Adult social care services provide support to individuals who need it to live independently as well as to their families and carers. Care can be delivered at home (known as domiciliary or home care), in residential or nursing homes, in supported living, in day-care centres, or through using a personal assistant. Care is largely supplied by private or not-for-profit providers and unpaid carers, though local authorities and the NHS also provide some care directly. For those who are eligible for publicly funded care, local authorities are responsible for commissioning and paying for at least some of their care.

The result is that many people are still exposed to “catastrophic care costs”² and others are denied publicly funded care by a means test that the government has not meaningfully updated since 2010/11.

The market of private providers who deliver most adult social care remains unstable: despite recent funding increases, average fees simply do not meet operating costs and are below the level that would allow firms to pay social care workers enough to improve recruitment and retention. The government’s proposal that local authorities would “move towards” paying a “fair cost of care” were met with tentative hope in the provider market, only for many to be left disappointed by the government’s decision to delay that reform until October 2025.

As with the NHS, the government is now relying on overseas workers from outside the EU to boost workforce numbers. This has been crucial in filling workforce gaps but is unlikely to be sustainable and can raise ethical concerns, such as exploitation of workers who rely on continued employment to remain in the country. Relying on international staff also does nothing to resolve the fact that social care workers are paid less than workers in comparable sectors – which makes it close to impossible to recruit and retain enough staff and results in high turnover.

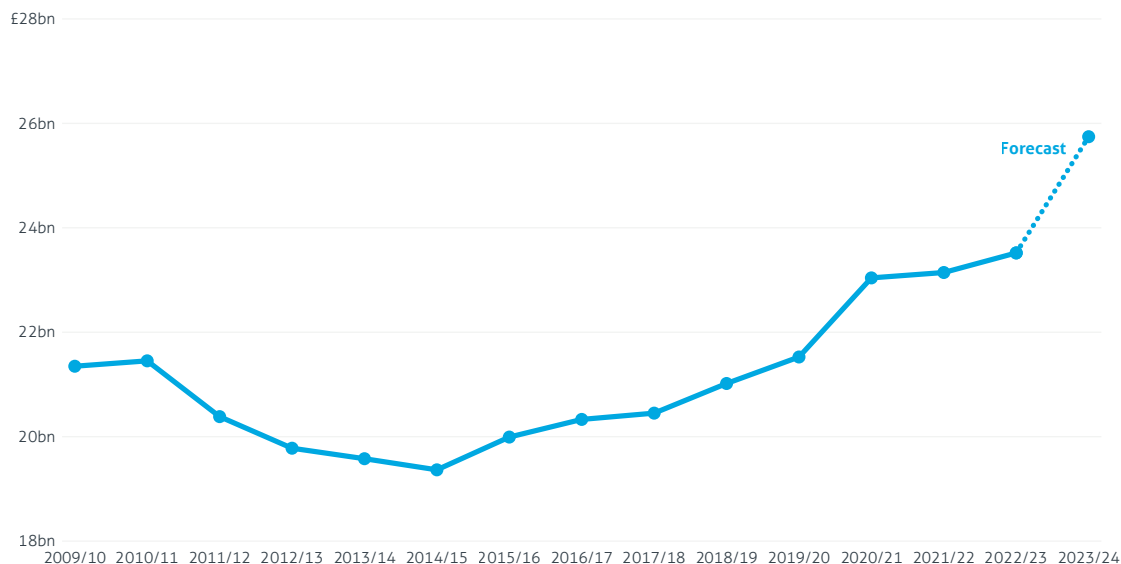
This range of problems makes it easy to forget that at its core adult social care should be about empowering people to live “gloriously ordinary lives”.³ The government’s failure on a range of these issues lets down those who rely on adult social care and is particularly concerning in the context of expected increases in demand.

This chapter looks at the performance of adult social care services that are funded by the state and does not assess the services available to those who pay for their own care.

Spending remains well above pre-pandemic levels

In response to the Covid-19 pandemic, the government substantially increased the amount it spent on adult social care, with a 7% real-terms increase between 2019/20 and 2020/21. Since then, spending has levelled off, with only a 0.4% real-terms increase in 2021/22* and a 1.6% real-terms increase in 2022/23.

Figure 3.1 **Spending on adult social care, 2009/10–2023/24 (2023/24 prices)**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report, England 2022–23' ('Appendix B, Table 5'); DLUHC, 'Local authority revenue outturn summary' 2021/22; and DLUHC, 'Local authority revenue account budget', 2023/24, supported by CIPFA. Notes: See Methodology for details of how figures have been put into 2023/24 terms and for how 2023/24 was forecast.

We forecast** that spending will rise substantially in 2023/24, by 9.5% in real terms, following increased investment at the 2022 autumn statement. That increase, however, comes in a year of soaring cost pressures for the sector, raising questions about the sufficiency of the funding to meet the government's goals, more on which below.

Measures from the 2022 autumn statement will increase funding for the service

The government announced an increase in spending on adult social care in the 2022 autumn statement over the last two years of this spending review period, 2023/24 and 2024/25. This funding increase came in the form of genuinely new grant funding, funding reallocated from delayed charging reforms, and a greater ability for local authorities to raise council tax.⁴ The split of those increases in funding is shown in Table 3.1.

* The GDP deflator that is used throughout *Performance Tracker* means that the increase between 2020/21 and 2021/22 looks smaller in real terms than in other publications, but larger in 2020/21 compared to 2019/20. For more details, see Methodology.

** For more details on how we forecast spending in 2023/24, please see Methodology.

Table 3.1 **Adult social care funding changes announced in the 2022 autumn budget**

Measure (£bn)	2023/24	2024/25	Total
Delay to charging reform	+1.3	+1.9	+3.2
New grant funding	+1.0	+1.7	+2.7
Council tax increases	+0.6	+1.1	+1.7
Total	+2.9	+4.7	+7.6

Source: Institute for Government analysis of HM Treasury, *Autumn Statement 2022*, supported by CIPFA.

In total, this amounts to £7.6bn of funding across the two years,^{5,6} but this is slightly misleading, as more than £3bn had already been announced for the implementation of charging reforms. Some £3.2bn of this money is also being disbursed across the two years as part of the Social Care Grant – a funding pot that can be spent on either adults’ or children’s social care.⁷ Councils typically spend about 40% of this funding on children’s social care,⁸ meaning that local authorities are likely to spend only £1.9bn of the £3.2bn on adult social care. Another £800m of the £7.6bn comes from the Discharge Grant, which is split 50/50 with the NHS, meaning that local authorities will receive only £400m.

The decision about levels of council tax increases is within the power of local authorities and if they choose to tax less, they must also expect to be able to spend less. But it is misleading of the government to announce funding that is not within its power to deliver. The ability to raise council tax is also not equal between all local authorities. Authorities with a large council tax base will disproportionately benefit from the ability to raise council tax by a given percentage, and those councils tend to be in less deprived areas where there is less demand for publicly funded adult social care. This means that the ability to raise council tax benefits the local authorities who need it least.⁹

We estimate* that spending on adult social care by local authorities and the NHS will be approximately £2.8bn more in 2023/24 than in 2022/23 in cash terms, an amount that would represent an approximate 10% real-terms spending increase from 2022/23. In comparison, real terms spending rose by 2.6% on average per year between 2014/15 and 2021/22. While this is beneficial, it is still unlikely to be sufficient to address all the problems in adult social care (discussed further below) and comes at the expense of long-awaited charging reforms.

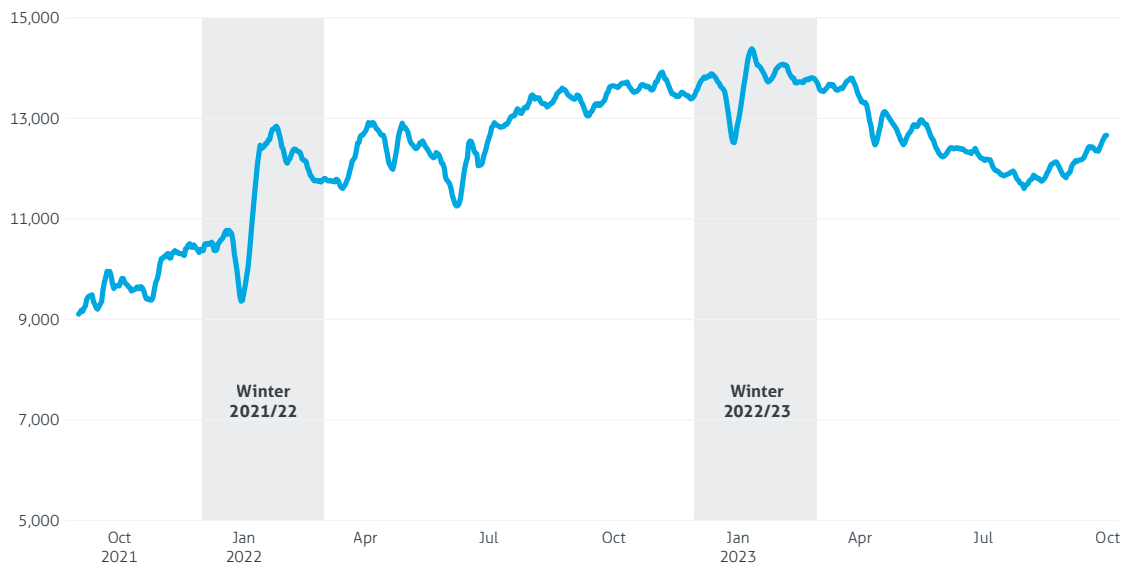
The government continues to rely on a model of ‘crisis-cash-repeat’ for the service

The winter crisis of 2022/23 saw the government fall back on a model of funding adult social care that it has relied on since at least 2015. In that time, the government has repeatedly topped up adult social care funding in response to short-term crises. This includes the announcement of the Improved Better Care Fund in 2015/16; the introduction of the adult social care support grant in 2016/17, which took money from some councils’ New Homes Bonus income to fund adult social care;¹⁰ and the provision of an extra £400m of resource for adult social care in December 2016.¹¹

* For more details, see Methodology.

This behaviour was turbocharged during the pandemic, as the government poured money into adult social care to compensate for how ill-prepared adult social care was for a respiratory pandemic.^{12,13} Then, in 2022/23, in response to a crisis in NHS urgent and emergency care, the government injected £700m of extra funding into the NHS and local authorities to increase adult social care capacity and improve delayed discharges out of hospitals.

Figure 3.2 **Delayed discharge from hospitals, September 2021 to September 2023**



Source: Institute for Government analysis of NHS England, 'Acute daily discharge situation report – time series: April 2021 to September 2023' ('Daily series' table), supported by CIPFA. 'Delayed discharge' refers to people who no longer meet the criteria to remain in hospital at the end of the day. 'Winter' here starts on 1 December and ends on 28 February each year. This shows a seven-day rolling average.

This approach of 'crisis-cash-repeat' is ineffective and represents poor value for money. Emergency funding in the winter of 2022/23 offers a good example of its shortcomings. First, government funding was announced and then disbursed late. The Adult Social Care Discharge Fund, worth £500m, was announced in September 2022, already well into the period when the NHS, local authorities and social care providers would have been planning their winter capacity. The £250m of emergency winter pressures funding was not announced until 9 January 2023 – far into the worst of the crisis.¹⁴ Even after announcing the Adult Social Care Discharge Fund in September, it took the government until December to disburse the first tranche – 40% of the total – to councils and the NHS, with the remaining 60% leaving central government coffers in January 2023.¹⁵

Second, the funding came with burdensome reporting requirements. The government required local authorities to detail how they planned to spend all their funding four weeks after it announced allocations. Thereafter, local authorities were expected to provide fortnightly activity reports, with a final report due in May 2023.¹⁶ For already under-resourced councils, this represented extra work with little obvious benefit to them.

Third, it is unclear whether the money has even been effective in its stated goal. The funding allocated in 2022/23 was intended to reduce the number of people in hospital who did not need to be there. But evidence that it was effective is mixed. On one hand, in the last week of February 2023, there were on average 13,720 people in hospital per day who were eligible for discharge, compared to 13,545 in the last week of November 2022 – an increase of 1.3%. On the other in the same period in 2021/22, delayed discharges increased by approximately 13%, and in the absence of funding, the level would likely have been higher in 2022/23. However, there is also evidence that while delayed discharge was largely flat in acute hospitals throughout the winter of 2022/23 (as shown in Figure 3.2), that may have been achieved at least in part by shifting people to other parts of the health and care system. Research by Nuffield Trust shows that there was an increase in the number of people delayed in community beds throughout the winter of 2022/23. There were approximately 5,300 people delayed in that setting at the start of November 2022, rising to just over 6,000 in March 2023 – an increase of roughly 13%.¹⁷ As Nuffield Trust says in its analysis: “It is vital that bottlenecks [in acute hospitals] are addressed rather than shifted elsewhere to the detriment of patients stuck in community beds.”¹⁸

It is fair to say that delayed discharges would likely have been higher in the winter of 2022/23 without the emergency funding, but that the same amount of money could have been spent more effectively to achieve better outcomes than it eventually did.

As an example of how longer-term, more consistent funding might have had better outcomes, we should look at how local authorities and providers actually spent emergency funding. Adult social care capacity is driven predominantly by the number of staff that providers can employ. But short-term funding made it difficult for providers to quickly and sustainably expand the workforce knowing that funding for salaries would run out at the end of winter.¹⁹ Even when providers were willing to take on more staff, there was a lag between creating a vacancy and employing and training an individual to do the job, meaning that the last-minute funding took a long time to filter through to increased capacity. Interviewees also reported that instead of waiting to fill vacancies, local authorities and providers spent most of the money on measures such as providing staff with one-off bonuses to discourage them from leaving,²⁰ bringing forward the scheduled national living wage increase, or using expensive agency staff who do not represent good value for money.²¹ This may have helped in the short term but will not provide the type of increased stability that longer-term investment in measures such as improved training or career progression might have.

Other examples of ‘crisis-cash-repeat’ also demonstrate poor value for money. The Department of Health and Social Care (DHSC) ran an evaluation of the Workforce Recruitment and Retention Fund, which allocated £462.5m of funding for growing the social care workforce during the pandemic. It found that “the number of staff recruited between the funded period and baseline period is not statistically significant”.²² Despite little impact on recruitment, there was improved retention, leading to an increase of 2.9 million staff hours compared to baseline. But that expanded capacity was expensive, costing the government £160 per additional hour,²³ far above the £10.11 that was the median hourly rate paid to care workers in the independent sector in March 2023.²⁴ The evaluation explicitly pointed to the short-term and last-minute nature of the funding as a reason for its ineffectiveness.

Without extra funding, reforming the charging model for adult social care in 2023 would have been difficult

In 2021, the government launched plans for major reform of adult social care in its *People at the Heart of Care* white paper²⁵ and of the charging model for the sector in the *Build Back Better* white paper.²⁶ But these plans have since been substantially pared back, with the government delaying plans for charging reform and, in April 2023, reducing funding allocated for other reforms. Those decisions break Boris Johnson's promise to solve the social care crisis "once and for all"²⁷ and push the question of reform into the next parliament, at the earliest.

The delay in charging reforms will likely be very disappointing to both the users of social care and those who work in the sector. However, interviewees said that the combined pressures of stabilising a market in crisis and implementing a complex set of charging reforms would have been difficult for local authorities, given the resources available to them.²⁸ Councils are under-resourced in terms of both funding – with many arguing that the money allocated for charging reforms was far below the amount needed to make them a success²⁹ – and staff and capacity.³⁰ A report from Newton and the County Councils Network estimated that local authorities would need to hire an additional 4,300 social workers – an increase of 39% from current numbers – and 700 more financial assessors, an increase of 25%.³¹ The current backlog in care assessments would also have been exacerbated by the government's charging reforms, which would have generated a large increase in assessments for local authorities to carry out.³²

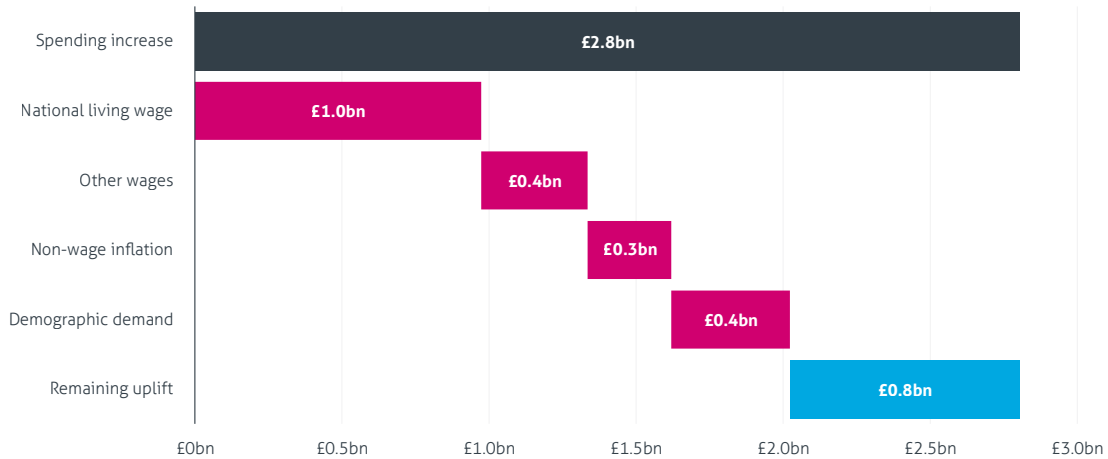
It is also important to emphasise that charging reforms would not have increased the amount of funding available for the sector, but rather changed the source of that funding. While the improved generosity of the means test would have helped some, reforms would not have changed many of the fundamental issues in the service, such as relatively low pay or care packages that leave many with unmet or under-met needs.

Cost pressures mean that increased funding might not achieve all the government's objectives

In total, spending on adult social care will rise by approximately £2.8bn between 2022/23 and 2023/24 in cash terms – the largest increase since at least 2009/10. This is a combination of new money announced in the 2022 autumn statement, previously planned changes in spending, and an additional £365m of funding through the Market Sustainability and Improvement Fund (MSIF),³³ which the government announced in July 2023. But providers' cost pressures are severe, so it is unlikely that the funding will achieve its stated objectives.

The sources of these cost pressures are multifaceted. First, a substantial proportion of the social care workforce are paid the national living wage (NLW). The government increased the NLW by 9.7% in April 2023, to compensate low-paid workers for rising inflation.³⁴ The Care Policy and Evaluation Centre estimates that 62.5% of the wage bill in adult social care is spent on staff who are paid the NLW,³⁵ meaning that any increases have a large effect on spending for adult social care. Using this proportion, the 9.7% rise in the NLW will cost providers approximately £1bn in 2023/24.

Figure 3.3 Cost pressures on 2023/24 uplift in spending on adult social care



Source: Institute for Government analysis of HM Treasury, *Autumn Statement 2022*, DHSC, 'Market Sustainability and Improvement Fund 2023 to 2024', Skills for Care, 'The state of the adult social care workforce', 2022, and OBR, 'Economic and fiscal outlook', March 2023, supported by CIPFA. Notes: Figures are IfG estimates; more details can be found in Methodology.

The rest of the social care workforce are paid above the NLW, but providers are likely to need to raise wages for those staff as well, or risk losing them to other employers that will pay them more, and to maintain wage differentials between more and less experienced parts of the workforce. Competition for staff comes from a range of sectors, but the employer that competes most strongly for staff is the NHS. If providers were to increase social care wages in line with the public sector pay settlement of 6% (to reduce the risk of a retention crisis), the non-NLW wage bill will have to increase by approximately £0.4bn in 2023/24.

The rising prices of other overheads – for example, fuel, food and utilities – are also increasing the cost of providing care. In the ADASS spring survey, 85% of local authorities in 2022/23 reported that overheads were driving up provider costs. This rose to 93% in 2023/24 and is considerably higher than the 16% of authorities who made the same claim in 2021/22.³⁶ Assuming that those costs will rise in line with the consumer price index, that will add a further £0.3bn to providers' costs.

Finally, increasing demand from an ageing population will mean that if the government wants to provide the same level of care in 2023/24 as in 2022/23 – assuming that demand will increase in line with the over-65 population, which is likely an underestimate given increasing demand coming from the working-age population – it will cost approximately an additional £0.4bn.

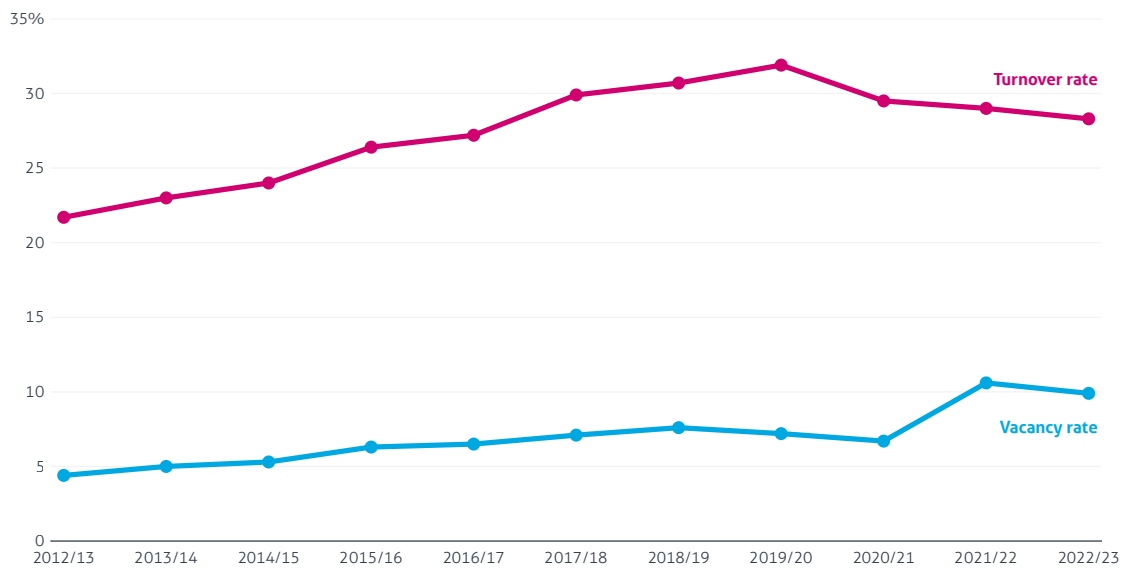
If all these cost pressures increase as assumed, there will be approximately £0.8bn of extra funding available in 2023/24 for meeting the government's objectives. This is a substantial increase that represents just over 3% of the amount the government spent on the sector in 2021/22. But the government has earmarked this funding for a wide range of objectives. These include: stabilising the provider market, expanding provision of care, and supporting hospitals to improve discharge during the winter. It is unlikely that this amount of funding will be able to achieve all of these objectives.³⁷

As a comparison, the government allocated only slightly less than that increase (£750m) to hospitals and the adult social care sector in 2022/23 solely to improve delayed discharge; an amount that was arguably not enough to achieve that relatively limited ambition.

Vacancy rates are falling, but remain high

In 2021/22, 10.7% (164,000) of jobs in adult social care stood vacant – the highest annual rate on record, up from 6.7% in 2020/21.³⁸ The vacancy rate declined somewhat in 2022/23, down to 9.9% (or 152,000 posts), though this remained higher than at any point on record apart from 2021/22.³⁹ Monthly estimates of vacancy rates suggest that they have been falling since October 2022.⁴⁰

Figure 3.4 **Adult social care workforce turnover and vacancy rates, 2012/13–2022/23**



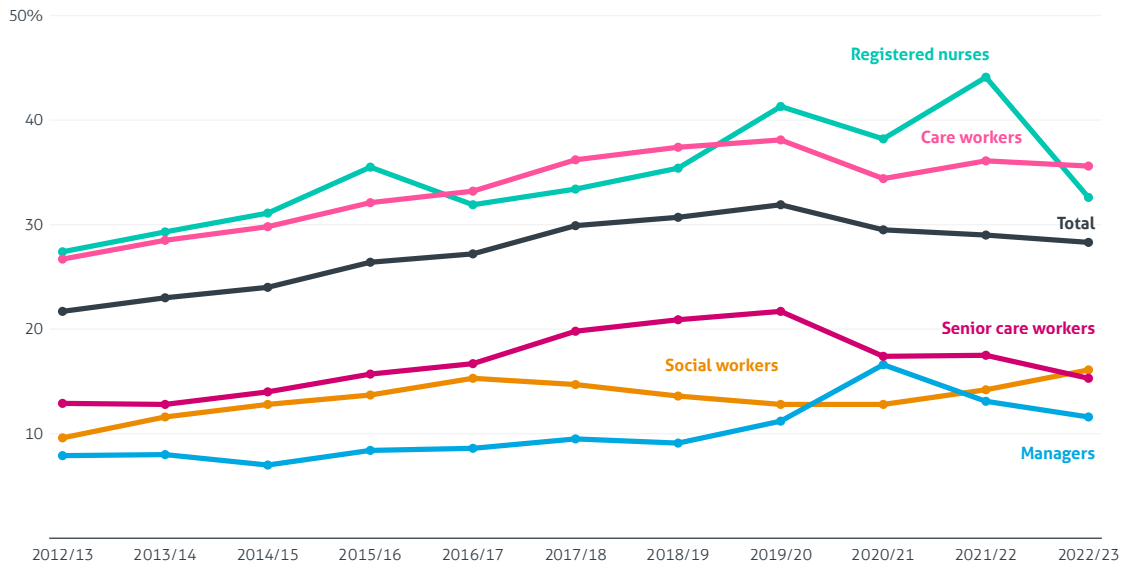
Source: Institute for Government analysis of Skills for Care, 'State of the workforce', 2022/23 and Skills for Care, 'Size and structure of the workforce', 2022/23, supported by CIPFA. Notes: 2012/13 was the first year in which Skills for Care published this data.

The primary reason for this reduction in vacancies is the success of international recruitment,⁴¹ more on which below. In addition, care workers who left the workforce in late 2021, when the government made Covid-19 vaccination a condition of employment,⁴² are slowly returning to the service. Finally, some providers may have stopped recruiting for jobs due to the difficulties in filling the roles or a decision to cut back the service offering entirely.⁴³

Staff turnover is high in some key roles

Staff turnover (the proportion of staff who left their role in the previous 12 months) fell marginally from 29% in 2021/22 to 28.3% in 2022/23 – the lowest level since 2016/17. But that top line number hides substantial variation between different roles within adult social care. Turnover rates are highest for care workers and nurses – at 35.6% and 32.6% respectively in 2022/23.⁴⁴ The turnover rate among registered nurses in the service was the highest on record in 2021/22, which could be because many left the service to work in the NHS, where pay and conditions tend to be better.

Figure 3.5 Adult social care workforce turnover rate, by staff group, 2012/13–2022/23

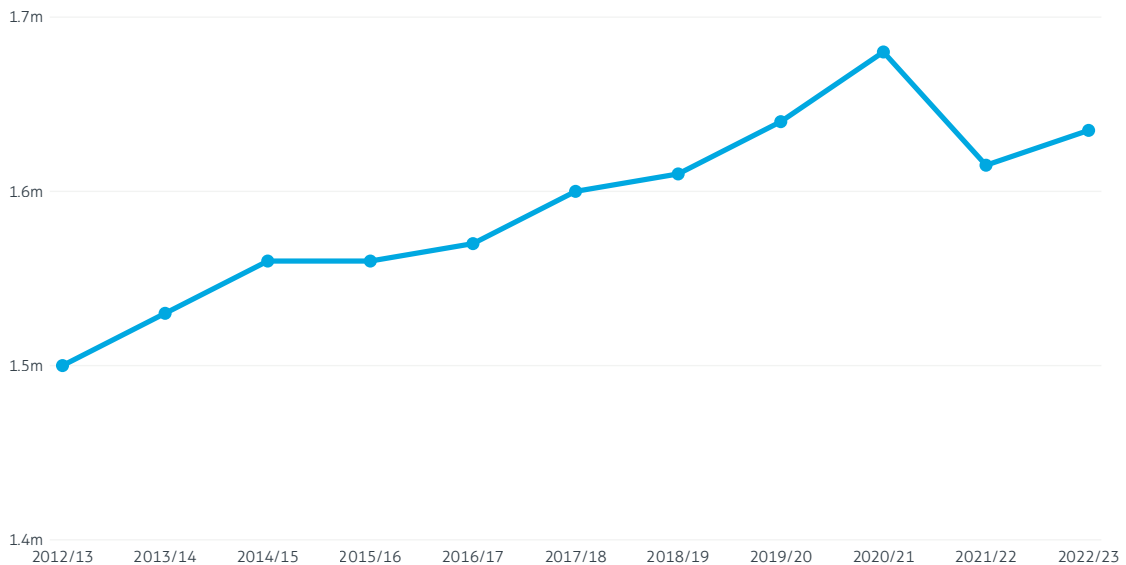


Source: Institute for Government analysis of Skills for Care, 'Workforce estimates', 2022/23, supported by CIPFA.

The size of the workforce recovered somewhat in 2022/23

Following a year in which the number of people employed in the adult social care workforce fell for the first time on record, there was a slight improvement in 2022/23. By the end of the year, there were 1,635,000 filled posts in the service – a 1.2% increase from 2021/22. This number, however, is still lower than in either 2019/20 or 2020/21 and indicates the service’s continued difficulties with recruitment and retention.

Figure 3.6 Adult social care workforce, 2012/13–2022/23



Source: Institute for Government analysis of Skills for Care, 'The size and structure of the adult social care sector and workforce, 2022/23' ('Chart 1'), supported by CIPFA. Notes: Comparable data is only available from 2012/13. This shows headcount.

Even with more workers in the adult social care workforce in 2022/23 than in 2012/13, the rate of growth is arguably not keeping pace with demand for the service. The Health Foundation estimates that the number of FTE staff in the social care workforce will need to rise to 1.76 million by 2030/31 to keep pace with demand⁴⁵ – an increase of 562,000 from the level of 1.20 million in 2022/23. This would require an annual growth rate of 4.9% – substantially higher than the 1.3% annual growth rate between 2012/13 and 2022/23.

The government has now published a long-term workforce plan for the NHS, and the National Audit Office,⁴⁶ the House of Commons Public Accounts Committee,⁴⁷ the Local Government Association⁴⁸ and the House of Lords adult social care committee⁴⁹ have all called on the government to undertake the same exercise for the adult social care sector. The last time the government published a workforce plan for the service was under Labour in 2009.⁵⁰ In its response to the adult social care committee's report, the government said that it had "set out [its] ambition for the social care workforce" in the *People at the Heart of Care* white paper,⁵¹ though that document does not provide the level of detail that the NHS workforce plan does, and in March 2023 the government cut the amount of money that it plans to spend on those reforms.⁵²

International recruitment has been crucial in filling vacancies

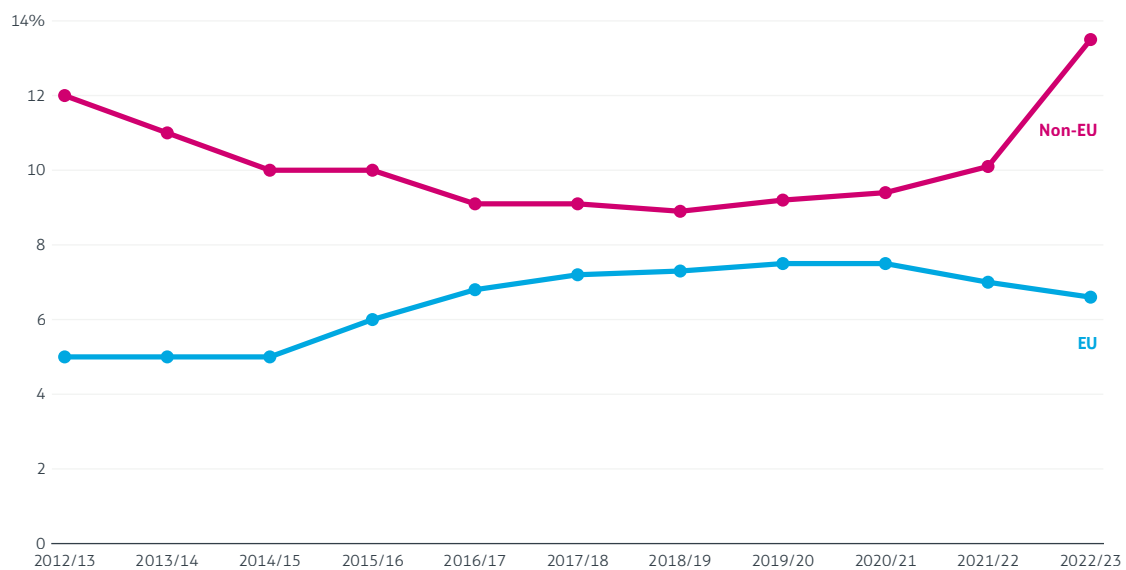
To help address the workforce issues in the service, the government placed care workers, senior care workers and home carers on the shortage occupation list (SOL) – sectors that are eligible for special dispensation to use immigration to fill workforce gaps⁵³ – in February 2022.⁵⁴ This has provided a vital source of workers for the service. In 2022/23 the government granted visas to 40,416 care workers and home carers, up from 113 in 2021/22 – a 35,666% increase.⁵⁵ The number of visas granted to senior care workers – who were added to the SOL in January 2021⁵⁶ – also rose in 2022/23, to 17,250 up from 6,763 in 2021/22 – a 155% increase.⁵⁷ The combined total of 57,666 visas granted for the sector equates to 3.6% of the total filled roles in the service in 2022/23, almost certainly explaining some of the recent fall in the vacancy rate. One interviewee reported that the social care sector would be "in a mess" without international recruitment.

There are, however, risks involved with this approach. First, the government set the salary threshold for eligibility for a visa at £20,960.⁵⁸ But variation in salaries around the country effectively creates a 'postcode lottery' as to whether providers will be able to recruit international staff.⁵⁹ For example, in March 2022 (the most recent time period for which we have data) the average salary for an FTE senior care worker was £20,800 in London and £19,500 in the West Midlands, meaning that posts in the latter were far more likely to pay less than the visa threshold, making it more difficult to hire internationally. Second, the politics of immigration creates uncertainty for providers and local authorities about whether they can rely on this as a sustainable source of workers.⁶⁰ Third, immigrant workers on low wages are more susceptible to exploitation by employers due to the eligibility of their visa being contingent on continuing employment.⁶¹

Brexit was expected to lead to a large exodus of EU workers from the social care workforce,⁶² but this has not yet transpired. There has been a fall in the number of EU staff – from a peak of approximately 107,000 in 2020/21 to 93,000 in 2022/23 – but it has not been as dramatic as might have been expected.

In contrast – and as would be expected given the large increase in visas for international recruits – the proportion of the social care workforce from outside the UK and the EU jumped to 13.5% in 2022/23 from 10.1% in 2021/22, representing a 36.8% increase in the size of that portion of the workforce in one year. In the same time, the number of British workers fell from 1.13 million to 1.11 million, a decline of 4.4%.

Figure 3.7 **Nationality of the non-British adult social care workforce, 2012/13–2022/23**



Source: Institute for Government analysis of Skills for Care, 'Workforce estimates', 2022/23, supported by CIPFA. Notes: The social care workforce in this instance applies only to those working in the local authority and independent sectors, and so excludes those working for direct payment recipients and those working in the NHS, as this is the only data that Skills for Care provides.

Recruitment and retention are hampered by low pay...

Part of the cause of poor recruitment and retention in the service is poor pay. The Migration Advisory Council argued in its report on the sector that "higher pay is a prerequisite to attract and retain social care workers".⁶³

Of particular importance is the rate of pay in the service compared to other sectors. The median hourly rate for care workers was £9.50 in 2021/22⁶⁴ (just 59p an hour above the NLW for adults) while sales and retail assistants were paid £9.64 an hour.⁶⁵ The difference is even more stark when comparing to similar roles in the NHS. A health care assistant (HCA) who is new in the role earned £10.50 an hour in 2021/22 and an HCA with two years' experience earned £11.30 – 18.9% more than a care worker. But this does not account for extra money that NHS employees can earn from overtime. Community Integrated Care estimates that when accounting for an HCA's additional pay, they earn 41.1% more than an experienced social care worker.⁶⁶

Pay has risen more quickly in the service since the introduction of the national living wage (NLW),⁶⁷ but is still below the level that would increase recruitment and improve poor retention in the sector. A solution that many have advocated is a sector-specific minimum wage to bring pay up to a sufficient level.^{68,69,70} Providers would often like to pay their employees more but are prevented from doing so by low fees from local authorities, who are in turn restricted by the funding they receive from central government. A sector-specific minimum wage would therefore ultimately require greater funding from local authorities, funded either by increased central government grants or by more money raised locally.

...as well as poor career progression and lack of training

It is not just pay, though, that makes working in the sector unattractive. A lack of training and progression also disincentivises care workers joining the sector and staying in post. First, the lack of formal training can mean that staff do not feel well equipped to do their jobs. Care workers often carry out skilled, complex work and yet only 46% of direct care staff have any form of qualification.⁷¹

Second, even when a carer is qualified there is little incentive for progression, with median senior care worker hourly pay only 75p higher than care worker pay.⁷²

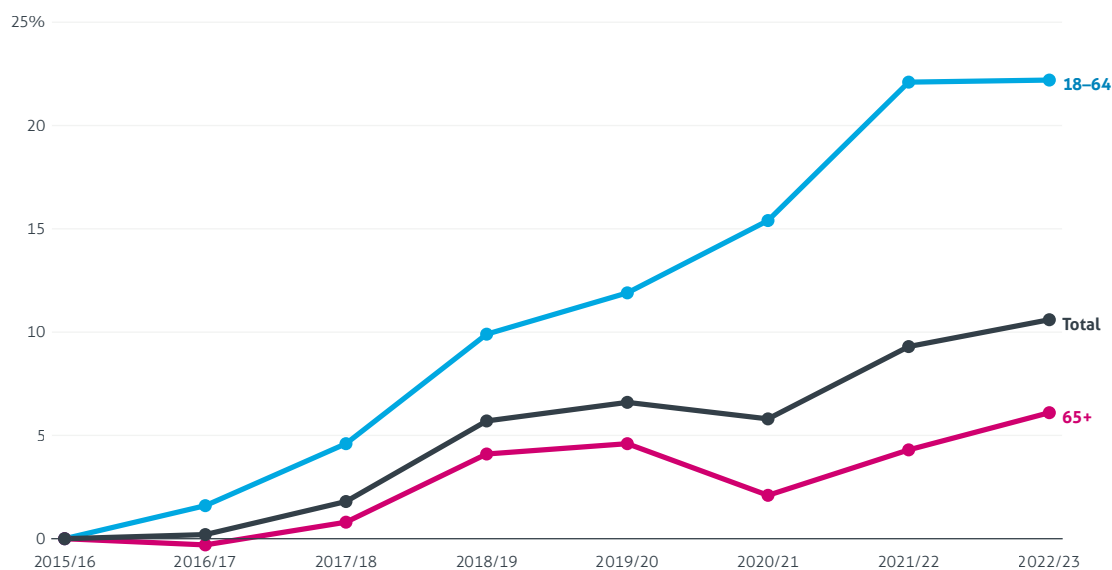
The benefit of training staff is well established. Work from Skills for Care shows that in 2021/22 turnover among staff with a qualification was 26.3% compared to 33.6% for those without a qualification. Older Skills for Care work surveying social care employers shows that investing in learning and development was cited as the most important intervention for improving staff retention.⁷³

The government was planning to address some of these issues with measures outlined in its white paper, *People at the Heart of Care*, which it launched in December 2021.⁷⁴ That white paper allocated £500m to improve training and career progression for staff.⁷⁵ But the government announced in April 2023 that it was reallocating half of this funding to improving discharge from hospitals to social care this winter.⁷⁶ Some of this funding has been allocated to the sector again, in the additional funding supplied by the government to local authorities in the MSIF.⁷⁷ But there are few specific requirements in the MSIF for local authorities or providers to offer training and qualification opportunities for staff, only to try to improve retention.

Requests for support increased after a drop in the first year of the pandemic

More than 45,000 people died from Covid-19 in care homes in the first two years of the pandemic.⁷⁸ That well-publicised crisis contributed to 2.4% fewer people aged 65 and over requesting state-funded care in 2020/21 compared to 2019/20. That year now appears to be an anomaly and in 2022/23 more than two million people requested support for the first time, a number that is 10.6% higher than in 2015/16.

Figure 3.8 **Change in requests for adult social care from new clients since 2015/16, by age group**

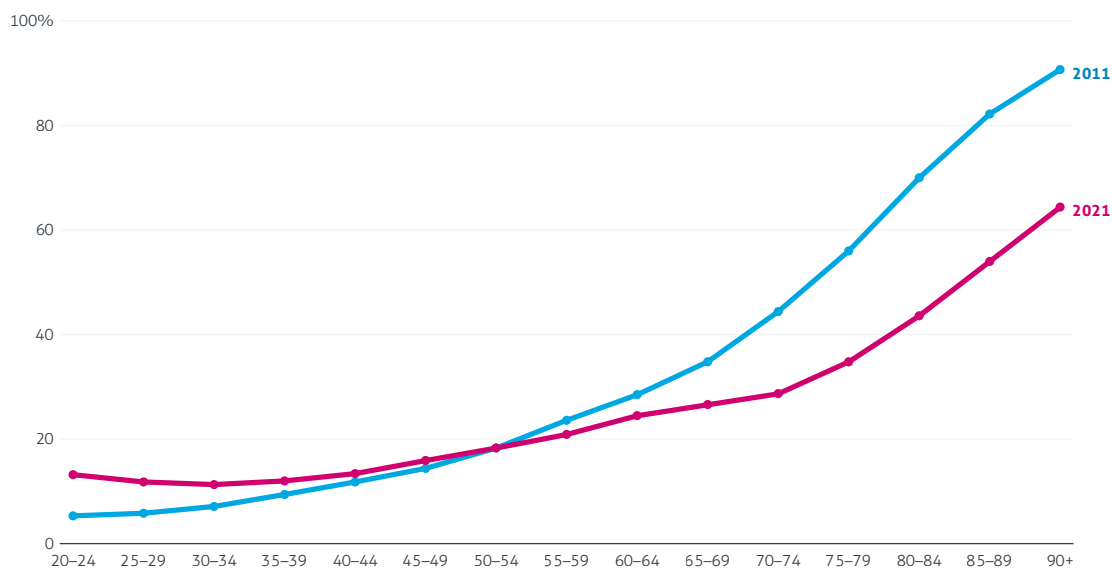


Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity' ('T8' table), 2022/23, supported by CIPFA. Notes: 2015/16 was the first year that NHS Digital published this information.

That decline in the first year of the pandemic could have implied that there was pent-up demand for the service that might come back as the government rolled out the vaccine in late 2020 and care homes improved their infection prevention and control. But while the number of requests from those aged 65 and over did increase again in 2021/22 and 2022/23 – by 2.2% and 1.7% respectively – there has arguably not been a large surge in requests that might have been expected given the drop during the pandemic. It is difficult to provide definitive reasons for this relative flattening off in demand, but there are some potential causes. First, more people aged 65 and over died in 2020/21 than would have been expected to in a normal year (either due to Covid-19 or with the involvement of Covid-19)⁷⁹ – in total, there were 91,700 excess deaths among the 65+ population in England in 2020/21 (equating to 0.9% of the 65+ population). This decline in the population will necessarily reduce the number of requests for care.

Second, there continues to be falling rates of disability among older people;⁸⁰ the census shows that among those aged 65+, the proportion of the population that were disabled declined from 53.1% in 2011 to 35.2% in 2021, though some of this change could be because the census question changed between 2011 and 2021. This reduction in the proportion of people identifying as disabled means that even though the 65+ population grew from 8.7 million to 10.4 million (20.1%), there were actually 936,165 fewer people aged over 65 who identified as disabled in the census.

Figure 3.9 Adults identifying as disabled in the census, by age band, 2011 and 2021



Source: Institute for Government analysis of ONS, 'Census: Disability by age, sex and deprivation', 2011 and 2021, supported by CIPFA. Notes: Figures relate to England only. The change between 2011 and 2021 is partially influenced by changes in the question asked in the census, though the ONS says that figures are "broadly comparable".

At the same time, the number of working-age adults requesting care reached a record high in 2021/22, and remained at more or less the same level in 2022/23. By the end of that year, there were 22.2% more requests for support from the working-age population than in 2015/16. This relatively large increase (compared to the 65+ population) is likely to be due to increasing rates of disability among working-age adults. The proportion of the population aged 20–64* identifying as disabled in the 2021 census rose from 13.4% in 2011 to 15.6% in 2021. That change may not sound substantial, but it equates to more than 900,000 additional working-age adults living with a disability within one decade. Interviewees speculated that this could be due to improvements in treating conditions, though the ONS also warns that a better understanding of mental health may have led to an increase in the reporting of disability among working-age adults.⁸¹

This increase also has implications for the sustainability of local authority finances; it is more expensive on average to provide long-term care to working-age adults. Over half of public expenditure on long-term care in 2021/22 was spent on adults aged 18–64, even though they accounted for only 35% of those accessing long-term care during the year.⁸² It seems unlikely that this trend will reverse. The Care Policy and Evaluation Centre estimates that "29% more adults aged 18 to 64 will need care in 2038 compared with 2018", an increase that is driven predominantly by rising numbers of people requiring learning disability support.⁸³ The same report estimates that the cost of providing publicly funded care to working-age adults will rise by 56.9% between 2023 and 2038⁸⁴ – an average of 3.0% per year.

* Data is for those aged 20–64 rather than 18–64 because the ONS only provides data in five-year age bands, meaning that 18- and 19-year-olds are grouped with 15-, 16- and 17-year-olds, making it impossible to disaggregate them.

Local authorities have not cleared the assessment backlog

ADASS surveys⁸⁵ estimate that there was a large increase in the number of people awaiting assessments for care during the pandemic, reaching a peak of 294,449 people in April 2022.

Table 3.2 **People awaiting adult social care assessments, November 2021 to March 2023**

	November 2021	January 2022	February 2022	March 2022	April 2022	August 2022	March 2023
Awaiting assessment	204,241	217,557	245,537	226,032	294,449	245,821	224,978
Proportion waiting 6+ months	20.2%	28.1%	26.4%	27.9%	25.1%	32.9%	36.5%

Source: Institute for Government analysis of ADASS, 'Spring survey report 2023' ('Figure 25: Number of people waiting for assessments, care and support, direct payments, or reviews and percentage change' table), supported by CIPFA. Notes: Comparable data is not available before November 2021.

This number has gradually declined in the year since, falling to 224,978 in March 2023 – a 23.6% decrease. But the number still stands 10.2% above the level in November 2021, when the data was first collected.

Notably, the number of people waiting more than six months has continued to increase, even as the overall number awaiting assessments has declined. The proportion of those waiting more than six months reached 36.5% in March 2023, up from 20.2% in November 2021. This implies that local authorities are providing assessments more quickly to those who have recently applied for an assessment than those that have been waiting longer.

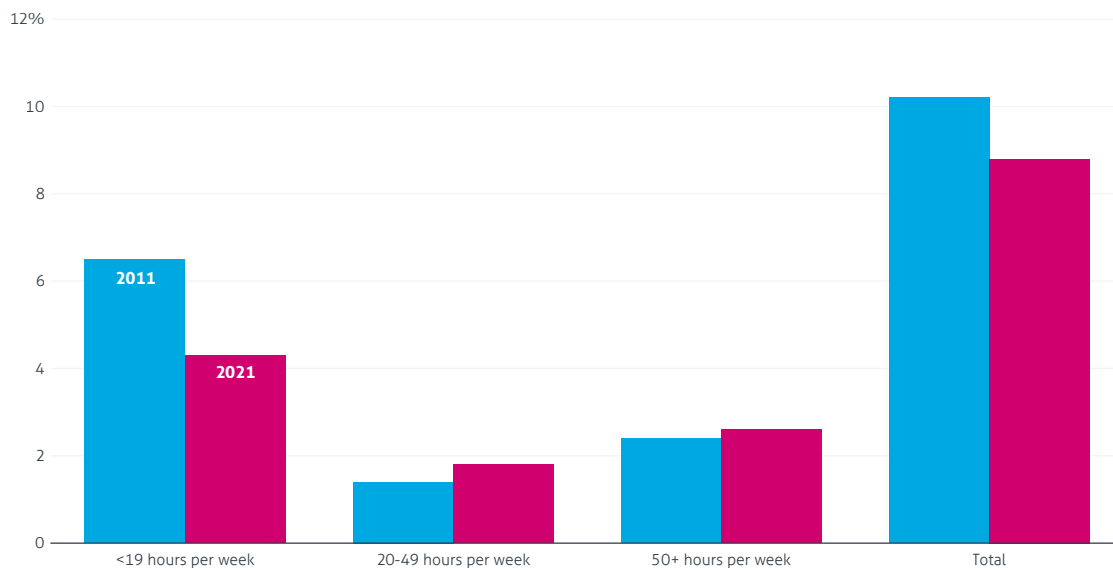
The failure to clear the backlog is caused at least in part by a lack of social workers in local authorities (see previous section): fewer social workers are trying to clear a larger number of assessments. The government has identified reducing social care waiting times as one of its targets for the Market Sustainability and Improvement Fund.⁸⁶

More people are providing large amounts of unpaid care

Unpaid care – when individuals care for friends or family members without being compensated for their time – is difficult to observe and quantify but is nonetheless vital to the operation of the adult social care sector in England. Carers UK and the University of Sheffield used 2021 census data to estimate that unpaid carers provide over 6 billion hours of unpaid care in England per year.⁸⁷

Despite the importance of this provision, there is little publicly available data about the extent of unpaid care. The primary source is the census, which provides a once-a-decade snapshot of unpaid care. The results from 2021 show that the proportion of people who provided unpaid care in England fell from 10.2% in 2011 to 8.8% in 2021.⁸⁸ That fall was driven mostly by fewer people providing small numbers of hours of care (less than 19 hours per week). In contrast, the population providing 20–49 hours and 50+ hours of care per week both increased, from 1.4% and 2.4% respectively in 2011 to 1.8% and 2.6% in 2021.

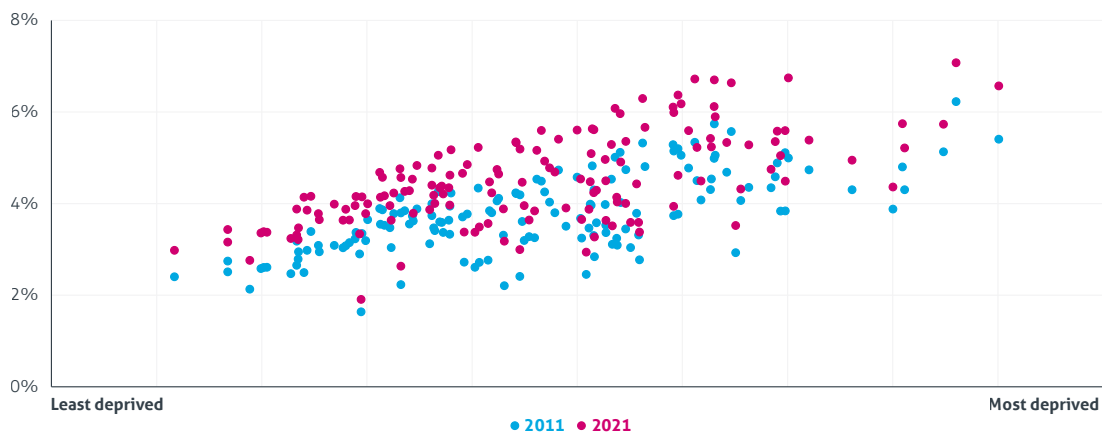
Figure 3.10 **Adult population providing unpaid care, 2011 and 2021**



Source: Institute for Government analysis of ONS, 'Provision of unpaid care', 2011 and 2021, supported by CIPFA.

The distribution of those providing large amounts of unpaid care is not even across the country. The more deprived a local authority, the more likely it is that someone living there is providing more than 20 hours per week of unpaid care.

Figure 3.11 **Adult population providing 20+ hours per week of unpaid care by local authority deprivation, 2011 and 2021**



Source: Institute for Government analysis of ONS, 'Census – provision of unpaid care', 2021 and DLUHC, 'English indices of multiple deprivation', 2019, supported by CIPFA. Notes: The x-axis orders local authorities from least deprived to most deprived by average index of multiple deprivation score.

There are, however, some caveats to this data. First, the question in the census changed and gave unpaid care a narrower definition in 2021 than in 2011, potentially leading to fewer people identifying with the definition. Second, the census was also taken during the first year of the pandemic, when lockdown and other social distancing measures may have affected people's answers.

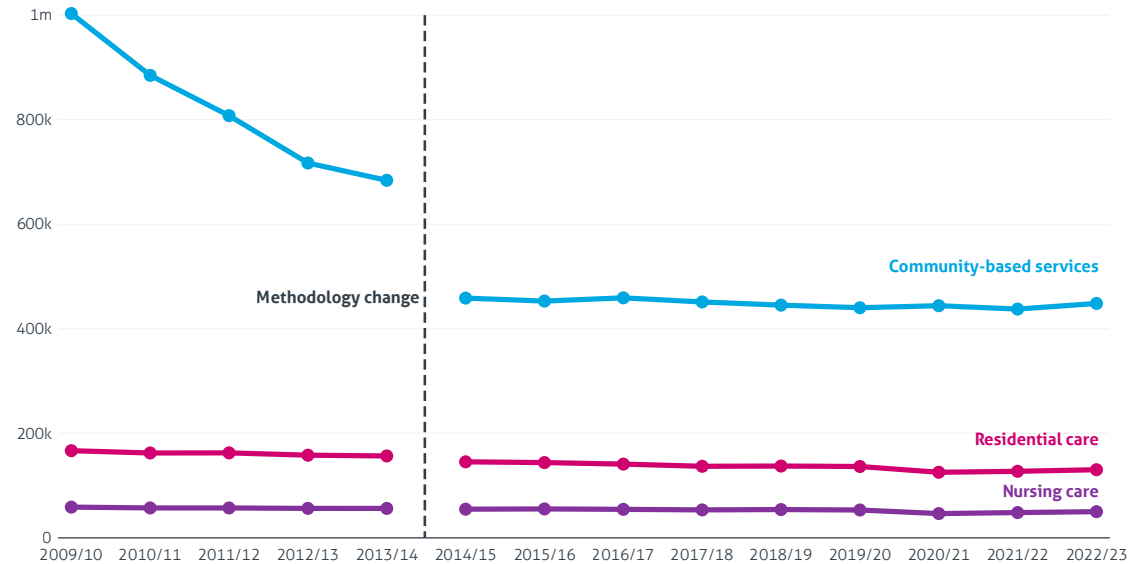
Whatever the reasons, there is a distinct lack of accurate information about the extent of unpaid care in the country. The government should publish a more frequent and consistent set of data to track the contribution that unpaid carers make. The government has stated its ambition to publish more data about unpaid carers in its *Care Data Matters* guidance,⁸⁹ though it is not expecting to publish any new datasets until at least 2025/26.

The number of people receiving long-term care rose in 2022/23

The number of people receiving long-term care* in 2022/23 grew for the first time since 2016/17. Despite that, there were still fewer people in long-term care at the end of the year than at the end of 2019/20, despite requests for support being 3.7% higher. The proportion of requests for support that result in long-term care has also fallen from 9.1% in 2016/17 to 8.5% in 2022/23. The reasons for the relative difficulty in accessing long-term care compared to the beginning and middle of the 2010s are multifaceted, but primarily this is due to local authorities rationing care to people who would previously have been eligible for care, as is discussed further below.

At the end of 2022/23 there were 628,895 people receiving long-term care, compared to 613,350 at the end of 2021/22 – a rise of 2.5%. Compared to 2014/15, there were 30,090 fewer people receiving long-term care at the end of 2022/23, a fall of 4.6%. In the same time, the number of requests for support grew by 10.6%.

Figure 3.12 **People receiving publicly-funded adult social care, by setting, 2009/10–2022/23**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity' ('T39' table), 2022/23, supported by CIPFA. Notes: This data refers to the number of people receiving long-term care at the end of the year.

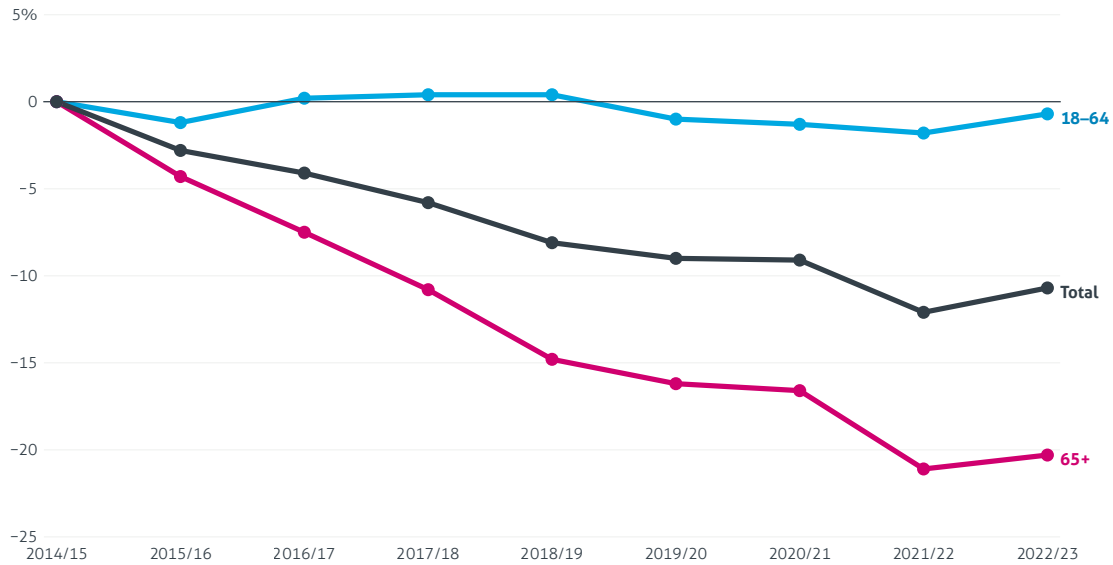
* Long-term care is defined as care "provided to clients on an ongoing basis and varies from high intensity provision such as nursing care, to lower intensity support in the community such as the provision of direct payments to arrange regular home care visits".

The fall since 2015/16 has been driven by a decline in the number of people aged 65 and over accessing care; there were 542,545 people from that age group in care at the end of 2022/23, down from 602,885 2014/15 – a 10.0% fall. In the same time, the over-65 population has increased, meaning that the per capita decline in the number of people receiving care was even greater. Despite a slight (1.0%) improvement in 2022/23 compared to 2021/22, the per capita number of people aged 65+ receiving long-term care is 20.3% lower than 2014/15.

The proportion of working-age adults – those aged 18–64 – receiving long-term care has risen slightly since 2014/15, by 2.1%. But adjusted for the increased size of the population there are fewer working-age adults receiving care than in that earlier year. By the end of 2022/23, the per capita number of working-age adults receiving care was 0.7% lower than in 2014/15. This is despite the increasing incidence of disability among that age group⁹⁰ – a metric that implies greater demand.

One possible reason why the proportion of the working-age population accessing long-term care has fallen less slowly than for older adults could be because there is a bias among commissioners that younger adults have a greater requirement for socialising than older adults, meaning they are more likely to have access to care that provides that benefit.⁹¹

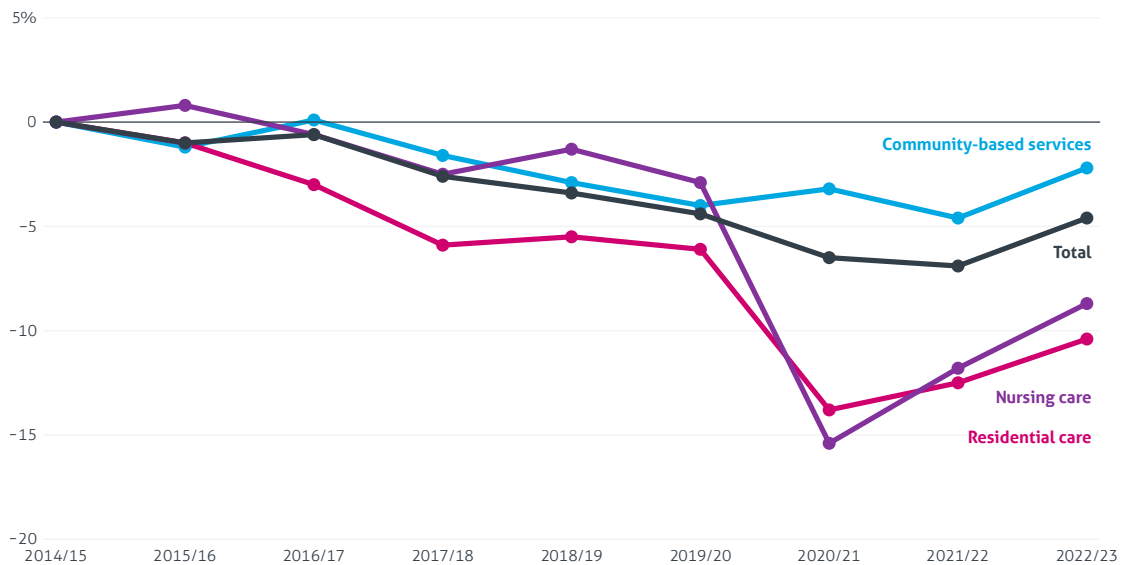
Figure 3.13 **Change in proportion of the population accessing long-term support since 2014/15, by age group**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2022/23 and ONS, 'Mid-year population estimates', 2022, supported by CIPFA. Notes: 2014/15 was the first year in which NHS Digital published this information. This refers to people accessing care during the year and is weighted by the number of people in each age band.

The number of people receiving nursing and residential care fell substantially in 2020/21 due to the well-publicised prevalence of Covid-19 in nursing and residential care in that year. That trend reversed in 2021/22 and 2022/23, and 180,430 people were receiving care in those settings at the end of the year – a 5.0% increase from the 171,855 people at the end of 2020/21. This is still 4.9% less than in 2019/20. In comparison, the number of people in community settings was 1.9% higher at the end of 2022/23 than in 2019/20, though still 2.2% lower than in 2014/15.

Figure 3.14 **Change in the number of people receiving care since 2014/15, by setting**



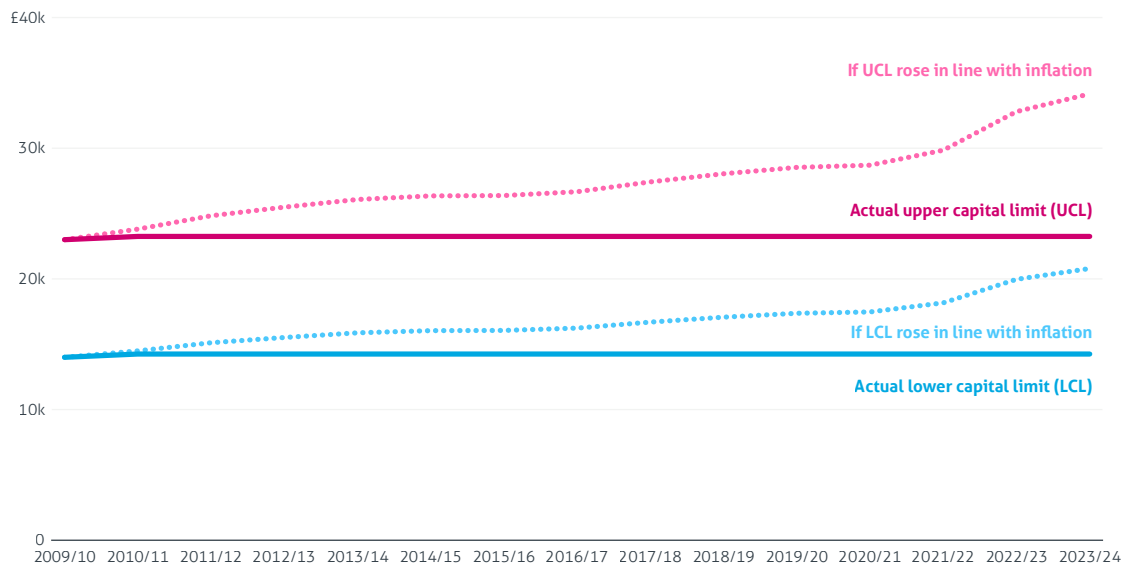
Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity' ('T39' table), 2022/23, supported by CIPFA. Notes: 2014/15 was the first year in which NHS Digital published this information. This data refers to the number of people in long-term care at the end of the year.

A decline in people receiving long-term support is unlikely to be because other models are working

This long-term decline in people accessing care comes despite more people requesting long-term support in 2022/23 than any other year on record, and largely reflects a long-term trend of rationing of adult social care services.

These services are firstly rationed by central government-set means and needs tests. The means test for social care – which tests an individual's wealth and therefore their eligibility for publicly funded care⁹² – has not risen in line with inflation since 2010. There has only been one increase in the lower and upper capital limits of the means test since 2009/10, which happened in 2010/11 when the lower limit rose from £14,000 to £14,250 and the upper limit rose from £23,000 to £23,250.

Figure 3.15 **Change in the means test for publicly-funded care, compared to inflation, 2009/10–2023/24**



Source: Institute for Government analysis of House of Commons Library, 'Adult social care: means-test parameters since 1997', p. 11, 2021 and OBR, 'Economic supplementary tables', ('1.7 inflation' table), March 2023, supported by CIPFA. Notes: Inflation in this instance is the consumer price index.

Both the lower and upper capital limits are now approximately 25% lower than they would be if they had risen in line with inflation since 2009/10. The failure to uprate the thresholds has made the means test less generous over time, making it harder for individuals to access care.

The government sets the criteria for eligibility for adult social care support, which is also known as the needs test. This was last updated in the 2014 Care Act.⁹³

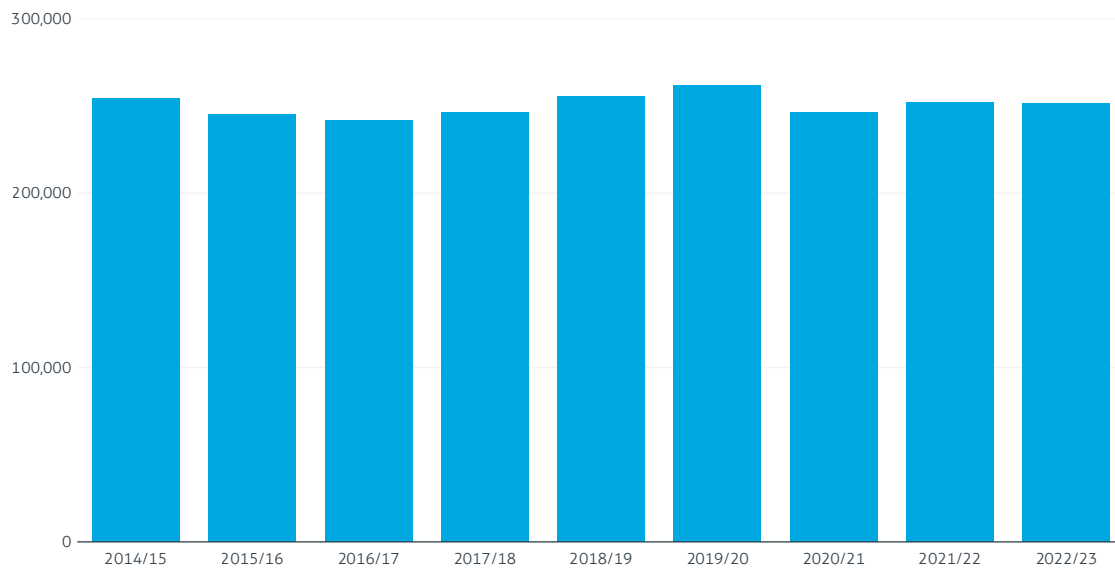
While the needs test has remained unchanged in recent years, local authorities are effectively using subjective judgments about need to further ration care to adults.⁹⁴ That rationing is a direct result of central government’s decision to cut grant funding by more than 30% since 2010,⁹⁵ without enough of an increase in locally raised revenue to offset those cuts.

Few local authorities would admit publicly* that they ration long-term care and would instead claim that they are following a 'strengths-based' approach to care – in which people are empowered to live and contribute to their communities, rather than relying on long-term support.⁹⁶ This approach has merits in theory – the goal of social care should be to empower individuals to live independently, and better integration into the community would help that – but it is difficult to point to strong evidence that it is happening in practice.

* Local authority interviewees frequently tell us privately that they have no choice but to ration services.

One indicator that authorities were pursuing this approach would be a substantial increase in the number of people receiving short-term care packages that are designed to increase individuals' independence and reduce their reliance on long-term care. These care packages are known as ST-Max packages.*

Figure 3.16 **Completed short-term adult social care packages to maximise independence, 2014/15–2022/23**



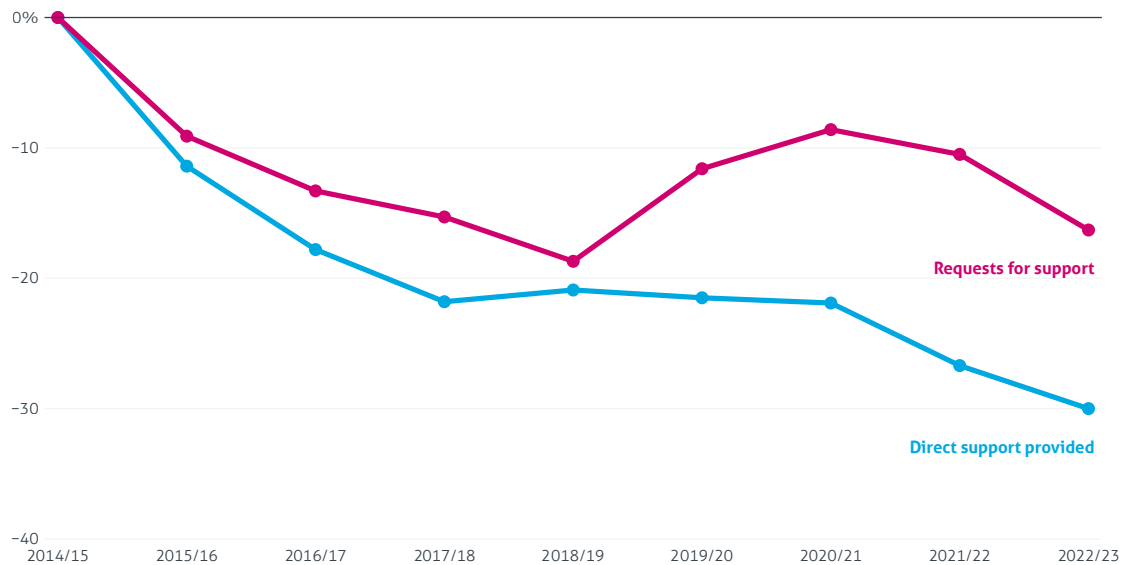
Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2022/23, supported by CIPFA. Notes: 2014/15 was the first year in which NHS Digital published this information.

But this is not the case. The number of people receiving ST-Max packages fell slightly in 2022/23 compared to 2021/22 – a total of 251,260 compared to 252,145 – and is 4.0% below the record high of 261,065 in 2019/20 and 1.2% below the 254,550 provided in 2014/15, when this dataset began. It is very likely that fewer people were able to access short-term care in 2020/21 and 2021/22 due to the pandemic, but there were only 2.8% more ST-Max packages in 2019/20 than in 2014/15 – years that were unaffected by the pandemic. Over the same period, the adult population grew by 4.8%, the over-65 population by 9.8%, and requests for care by 4.6%. These are all imperfect proxies for demand for adult social care, but if local authorities were investing in short-term care to improve the likelihood of someone not having to access long-term care, it would be reasonable to expect that the number of ST-Max packages would have grown more quickly than 2.8%.

Another indicator that local authorities were shifting to a strengths-based approach would be increasing support to carers, as this would allow those they care for to live more independently, without care from providers. But once again, there is no evidence that this is happening: while the number of requests for support for unpaid carers has fallen since 2014/15 – by 16.3% in 2022/23 – the amount of direct support provided by local authorities has declined by more, falling 30.0%.

* ST-Max is defined as "episodes of support provided that are intended to be time limited, with the intention of maximising the independence of the individual and reducing/eliminating their need for ongoing support by the [council with responsibility for adult social services]".

Figure 3.17 Change in requests for support and direct support provided to carers by local authorities, since 2014/15



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity' ('T47' table), 2022/23, supported by CIPFA. Notes: 2014/15 was the first year that NHS Digital published this information.

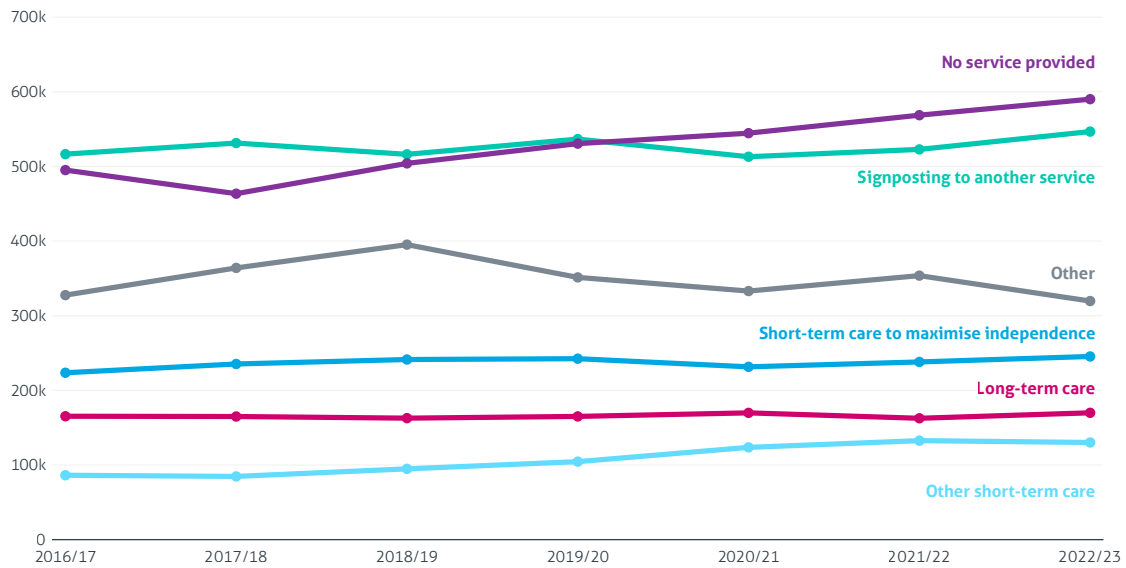
It has also been argued to us by the DHSC that local authorities are taking a holistic approach to meeting people's care needs, which means focusing more on prevention and directing people towards other services for which there is little or no data.

However, there is no indication in local authority spending data that spending is increasing on preventative services^{97,98} (see the 'Neighbourhood services' chapter for further details). On the contrary, local authorities spend remarkably little on information and early prevention as part of their adult social care spending; only 1% of the amount that councils spent on adult social care in 2021/22 was directed towards this end. That amount has also largely remained flat over time, and is actually 0.5% less in real terms than the amount spent in 2015/16.

The data also does not support the assertion that local authorities are directing people to other services. The proportion of requests for support that resulted in 'signposting to another service' – in other words, giving individuals information about other services that might better meet their needs – has fallen over time: in 2016/17 28.5% of requests resulted in 'signposting'; by 2022/23 this was 27.3%. In contrast, between 2016/17* and 2022/23, the proportion of requests for support that led to no service being offered rose from 27.3% to 29.5%, surpassing 'signposting' as the most common outcome of a request for support in 2020/21.

* 2016/17 is the starting year here because it is the first year for which there is a time series of reasons that is then consistent through to 2021/22.

Figure 3.18 Requests for adult social care, by outcome, 2016/17–2022/23



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity' ('T10' and 'T11' tables), 2022/23, supported by CIPFA. Notes: 'Other' includes end of life care, NHS funded care, ongoing low level support, and no services provided due to the death of the person requesting support. 2016/17 is the first year for which there is comparable data.

Given all the evidence available, it is reasonable to infer that the main reason for declining rates of people accessing long-term support is the rationing of care. Indeed, the Institute for Government is not alone in its assessment that local authorities have been forced to ration care. In 2018, the Health and Social Care Committee and the Levelling Up, Housing and Communities Committee concluded that “as a result of funding pressures, local authorities are providing care and support to fewer people and concentrating it on those with the highest levels of need”⁹⁹ – rationing by another name. The King’s Fund¹⁰⁰ and Nuffield Trust¹⁰¹ also reached the same conclusion.

As a result of rationing, unmet need is a major problem. In March 2023, Age UK estimated that 2.6 million people aged over 50 in England were living with some form of unmet need¹⁰² – about one in eight people in that age group.¹⁰³ It is difficult to fully quantify the impact of unmet need, but it is likely that it increases demand for other services such as general practice and accident and emergency.¹⁰⁴ Research from the Institute for Fiscal Studies shows that the average cut of £375 in per-person spending on adult social care between 2009/10 and 2015/16 led to an additional 0.09 visits per person to A&E among those aged 65 and over, compared to the average of 0.37 visits in 2009/10 – a 24.3% increase.¹⁰⁵

4. Children's social care



Children's social care: key figures

- **£11.1 billion** – the amount spent by local authorities on children's social care in 2021/22, up 41.6% since 2009/10.
- **66.2%** – the real-terms spending increase on children's residential care between 2015/16 and 2021/22.
- **650,270** – the number of referrals to children's social care in 2021/22, up 8.8% since 2020/21 and up 1.1% since 2019/20.
- **82,170** – the number of children in care in 2021/22, up 27% since 2009/10.
- **17.1%** – of children starting an episode of care were unaccompanied asylum-seeking children.
- **31,643** – children and family social workers in post (full-time equivalent: FTE) in 2022/23, down 2.7% on 2021/22 and the first fall in the data series.

Introduction

Local authorities are struggling with serious workforce shortages as the sector faces the highest level of turnover since 2013 and the first decline in overall numbers of children's social workers in a decade, even as the need for social workers rises. Difficulties in recruitment and retention have exacerbated the sector's existing over-reliance on agency staff, fuelling higher costs. Alongside these cost pressures, a shortage of residential placements is driving higher prices, adding to the financial squeeze on other children's services and wider local authority budgets, as outlined in the 'Neighbourhood services' chapter. This squeeze is part of a long-term trend that has seen spending on acute services such as family support rising by 43.2% between 2009/10 and 2021/22 at the expense of universal and preventative services such as Sure Start children's centres and other spend on children under five, which fell by 73.4% over the same period.

Meanwhile, demands on the sector are increasing. Referrals to children's services have returned to pre-pandemic levels while the number of children in care continues to rise. There is also evidence that cases have become more complex, with additional pressures from a record level of unaccompanied asylum-seeking children. Though the

government has recently outlined a future vision for the sector,^{*} it has been criticised for lacking the funding or policy changes needed to tackle the scale of problems and as such it may struggle to improve the quality of social care provision.

This chapter examines the current state of children's social care in England. These services are provided by upper tier local authorities, which are legally obliged to provide support for disabled children, to protect children from harm, and to take responsibility for 'children in care',^{**} including through foster and residential care placements.

Spending on children's social care is increasing pressure on local authority budgets

Local authorities spent £11.1bn on children's social care in 2021/22, up £0.5bn in a year – of this, £0.48bn was attributable to pandemic-related expenditure, such as higher residential care and agency staff costs.^{***} Between 2009/10 and 2021/22, spending increased by 41.6% in real terms. By comparison, the number of children in England grew by less than 10% over the same period.

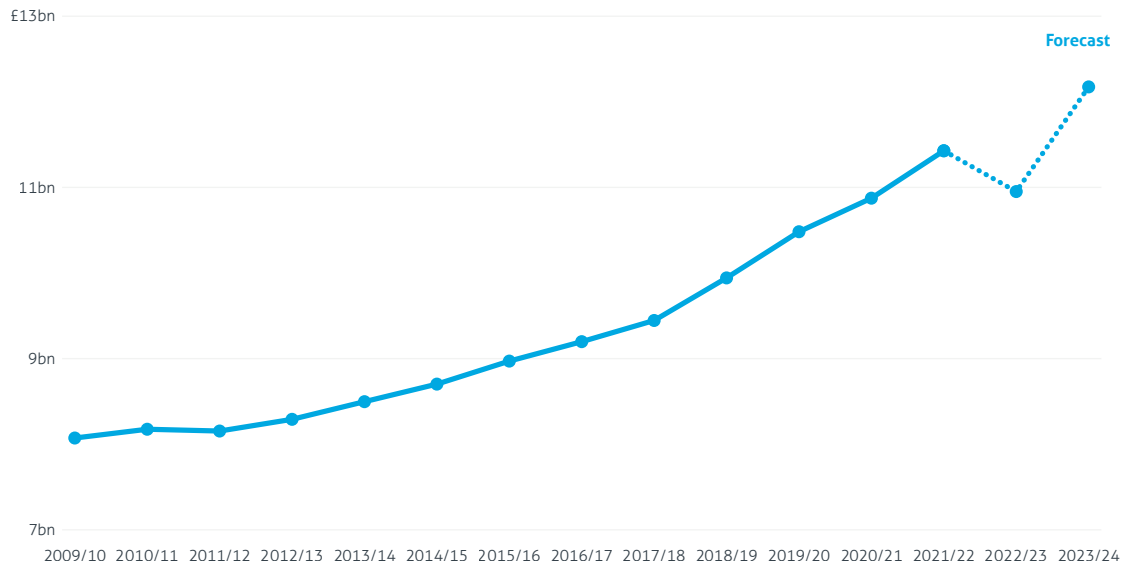
This sustained increase in children's social care spend continues to squeeze the budget available for other children's services and other areas of local authority spending. Nationally, councils ended up spending more than they budgeted on children's social care each year from 2014/15 to 2019/20.¹ Local authorities have continued to overspend, and in 2021/22, 46% of councils overspent their budgets by at least 20%, while 10% of councils overspent their budgets by at least 40%.² In Bolton, overspend on children's services amounted to almost 10% of the local authority's entire net revenue budget for 2022/23.³

^{*} Department for Education, *Stable Homes, Built on Love: implementation Strategy and Consultation: Children's Social Care Reform 2023*, February 2023, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1147317/Children_s_social_care_stable_homes_consultation_February_2023.pdf

^{**} A child who has been in the care of their local authority for more than 24 hours is known as a looked-after child. Looked-after children are also often referred to as children in care.

^{***} For more details on the breakdown of this spending see Davies N and Fright M, *Performance Tracker 2022/23: Spring update*, 'Children's social care', Institute for Government, 23 February 2023, <https://www.instituteforgovernment.org.uk/performance-tracker-2022-23/childrens-social-care>

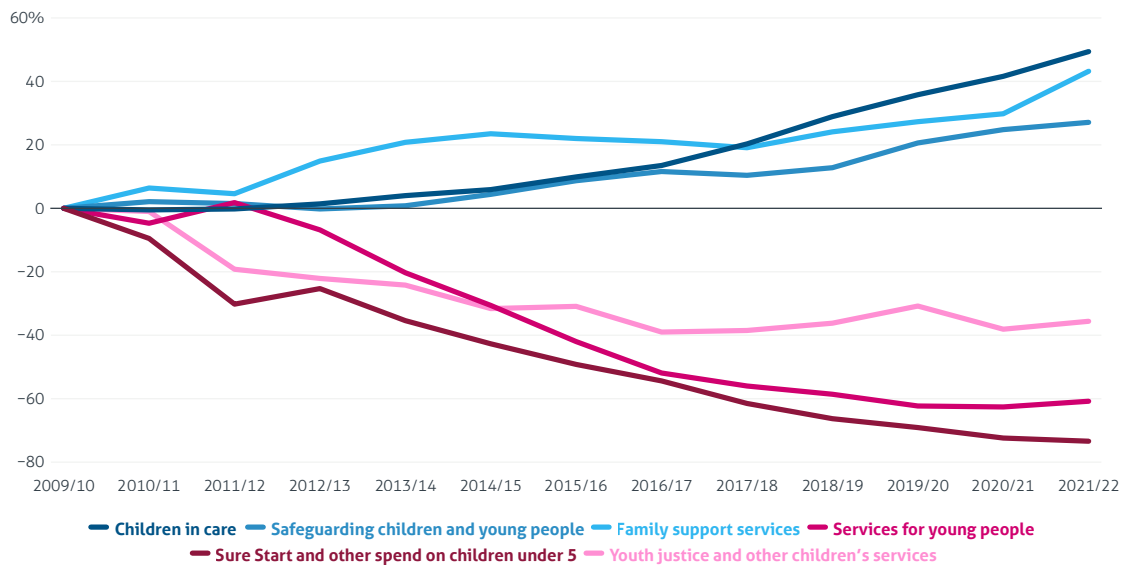
Figure 4.1 Spending on children's social care since 2009/10 (real terms)



Source: Institute for Government analysis of DfE, 'LA and school expenditure' ('S251 Outturn – Children and Young People's Services' table), 2009/10–2021/22, supported by CIPFA. Notes: See Methodology for details of how figures have been put into real terms. Details on forecasts can also be found in Methodology.

Decision makers have prioritised spending on more acute children's social care at the expense of other services for children. Between 2009/10 and 2021/22, spending on safeguarding children and young people increased by 27.1%,* and on children in care by 49.4%. Over the same period, spending on other services for young people (which includes youth work, activities for young people and teenage pregnancy services) was cut by 60.8%, while spending on Sure Start children's centres and other spend on children under five fell by 73.4%.

Figure 4.2 Change in local authority spending on children's social care and non-social care services in since 2009/10 (real terms)



Source: Institute for Government analysis of DfE, 'LA and school expenditure' ('S251 Outturn – Children and Young People's Services' table), 2009/10–2021/22, supported by CIPFA. Notes: See Methodology for details of how figures have been put into real terms.

* Figures have been deflated using a 'smoothed-deflator' for all financial figures. For more details on this see Methodology.

The government's independent review of children's social care argued that prioritising acute responses at the expense of earlier support can lead to cases escalating.⁴ Consequently, the review proposed a roughly £2.6bn uplift to children's social care spending between 2023 and 2027 and a rebalancing of priorities away from crisis interventions towards earlier stage interventions with an annual amount of £1bn ring-fenced for family help. However, the government has not implemented this recommendation.

Higher residential care costs are driving up spending pressures in social care

Between 2015/16 and 2021/22, the amount spent on children's residential care increased by 66.2% in real terms. This includes a 14.6% increase in 2021/22 alone, the largest real-terms increase since this data started being collected in 2015/16.⁵ This is a major factor driving overall spending increases because spending on residential care comprised approximately a third of spending on children in care and a seventh of all children's social care spend in 2021/22.

Higher costs have been driven by both supply constraints and demand pressures. On the supply side, children's homes and other forms of residential care have few places available, with 29% of providers in February 2023 reporting over 95% occupancy, up from only 15% of providers in June 2019.⁶

Some areas face particularly significant shortfalls in local provision. The Competition and Markets Authority (CMA) found that North West England has 23% of all places in children's homes, yet 17% of children in care, while London has just 6% of total places in children's homes but 11% of the country's children in care.⁷ Lack of adequate local accommodation has negative consequences for children; for instance, leading to them being moved far from family and wider kinship networks.* More than 33% of children in care living in children's homes, secure homes or semi-independent homes are placed more than 20 miles from their home.⁸ As at March 2018, in England more than 2,000 children in care were more than 100 miles from home.⁹

Accommodation for children with complex and specialist needs is the scarcest; for example, there are no secure children's homes** in London or the West Midlands.¹⁰ Ofsted analysis showed that, as of March 2020, only 5% of children's homes said that they could accommodate complex health needs.¹¹

The complex needs sector has come under additional scrutiny following the harrowing treatment of children under the care of the Hesley Group.¹² The government is implementing changes to the sector and oversight regime for complex needs;¹³ this has led some providers to withdraw from the market, reducing the supply of accommodation still further.¹⁴

* Children in kinship care live either full-time or the majority of the time with family friends or relatives who are not their parents.

** Secure children's homes house children between the ages of 10 and 17 and restrict their liberty to ensure their safety. This can occur if they have been remanded or sentenced to custody or placed there on welfare grounds. For further details see <https://frg.org.uk/get-help-and-advice/a-z-of-terms/secure-childrens-home>

Problems with supply have been compounded by higher demand. Higher than usual numbers of foster parents are withdrawing,* which has led to a shortfall in foster carers,¹⁵ meaning local authorities have to make greater use of residential care. Second, following criticism from campaigners and the children's commissioner,¹⁶ the government withdrew the use of unregulated accommodation for under 16-year-olds from September 2021.¹⁷ While intended to improve the quality of children's homes through better oversight,¹⁸ the practice may be continuing in some areas, and may have placed extra demands on the system. This pressure will intensify given the decision to extend this to 16- and 17-year-olds from October 2023.¹⁹ Research commissioned by the County Councils Network (CCN) suggests that the Department for Education (DfE) has allocated £123m to cover the impact of these changes over the next three years, but when taking account of demand growth, the CCN estimates the total cost to local authorities could be nearly three times this.²⁰

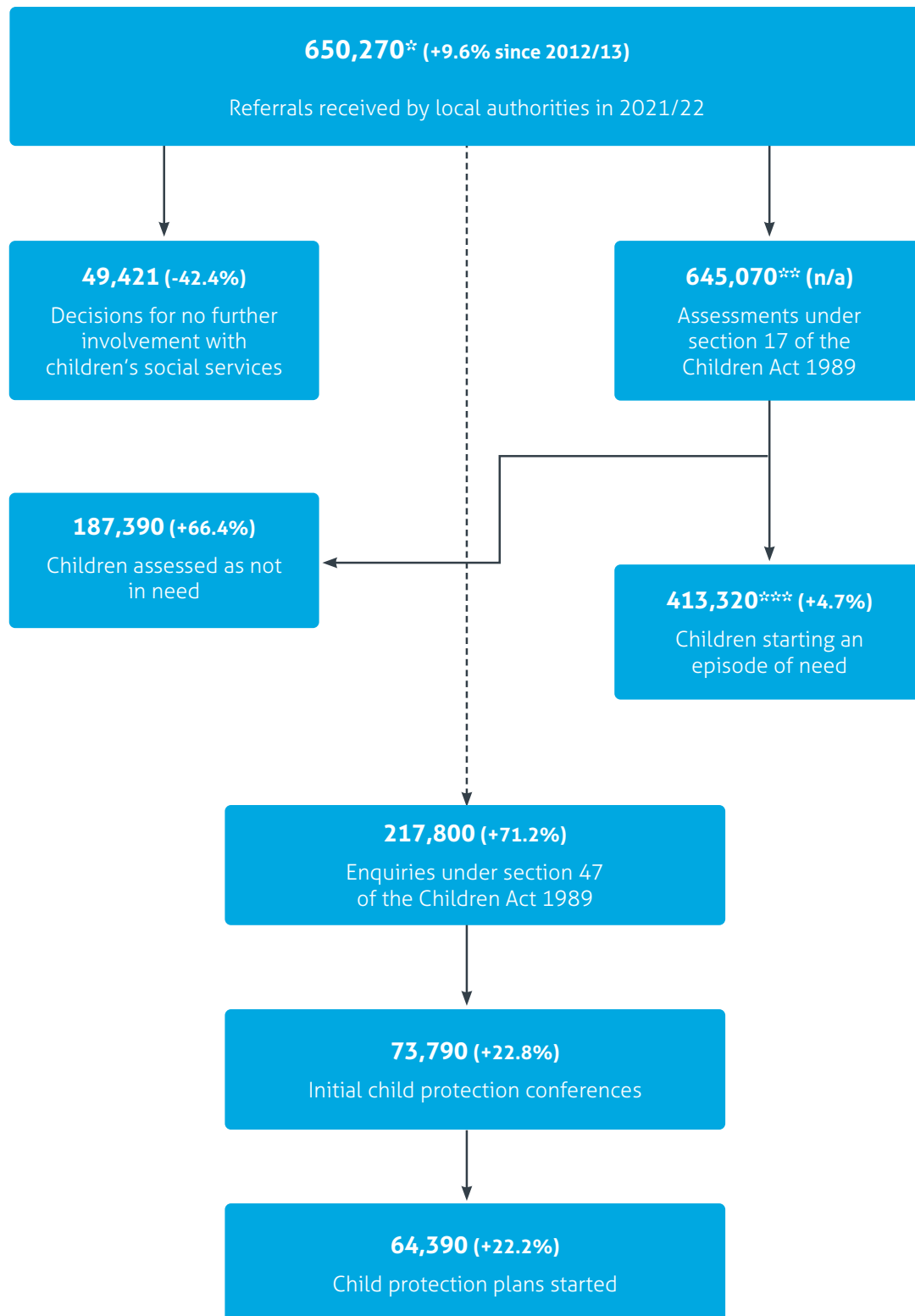
Costs have also been driven up by the profit levels of private residential care providers, which account for 83% of residential care places. A recent report by the CMA found that private providers were making higher profits through higher prices and provision that did not always meet the needs of children, such as a lack of local placements and difficulties accessing appropriate care, therapies or facilities.²¹ Some industry surveys, though, have suggested higher inflation, costs of living and staffing recruitment and turnover problems might have decreased operating profits over the past year.²²

The DfE has now labelled the risk of market failure for children in care placement as "critical to very likely" over the 2023/24 financial year due to rising prices and its assessment that local authorities are increasingly unable to afford appropriate placements to meet the needs of children in their care.²³

* It remains unclear why more foster carers are exiting the sector. Analysis from ADCS suggests that this may be linked to carers re-evaluating priorities since the pandemic and broader cost of living pressures. See https://adcs.org.uk/assets/documentation/ADCS_Safeguarding_Pressures_Phase_8_Full_Report_FINAL.pdf, p. 92.

There are increasing demands on the social care sector

Figure 4.3 Key stages in children's social care referrals

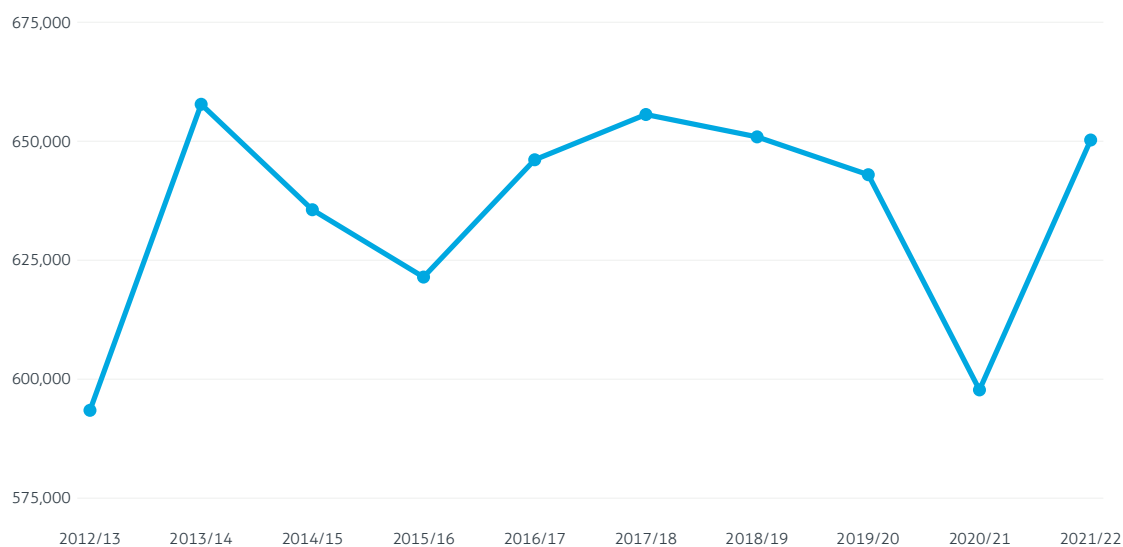


Source: Institute for Government analysis of DfE, 'Characteristics of children in need' ('Table A1', 'Table B1', 'Table C1' and 'Table DI4'), supported by CIPFA. Notes: Figure adapted from Figure 3 in the 2019 NAO report *Pressures on children's social care*. Children assessed as requiring support under section 17 of the Children Act 1989 are defined as children in need. Where there are reasonable grounds to suspect a child is or will likely suffer significant harm, a local authority may launch an investigation into their welfare under section 47 of the Children Act 1989. * Referrals: there may be more than one referral per child across the year. ** Assessments plus no further involvement does not sum to total number of referrals: multiple referrals may lead to one assessment and one referral to multiple assessments. *** Children in need plus not in need do not sum to total number of assessments: there may be more than one assessment and more than one episode of need per child across the year.

Referrals have returned to pre-pandemic levels

Referrals to children's social care fell sharply during the pandemic but have now returned to pre-pandemic levels, rising by approximately 52,500 in 2021/22 (8.8%).

Figure 4.4 Referrals to children's social care, 2012/13–2021/22



Source: Institute for Government analysis of ONS, 'Characteristics of children in need' ('Table C1'), 2022, supported by CIPFA. Notes: Following a methodology change in 2018 and revisions to earlier data, comparable figures are not available before 2012/13. If a child has more than one referral in a year, then each referral is counted.

Part of the reason for the increase in referral numbers is that, as lockdown restrictions were reduced, potentially vulnerable children have had greater contact with public services. Schools are the second highest source of referrals to social care; they referred 59% more cases in 2021/22 than in 2020/21, reversing the large fall (30.6%) in referrals seen between 2019/20 and 2020/21.

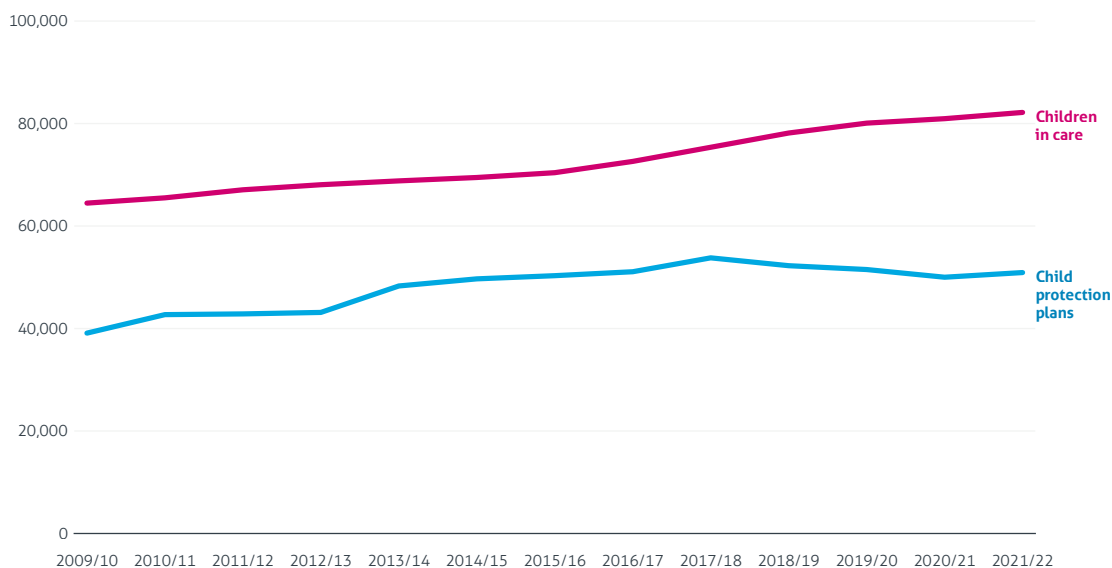
Referrals are now slightly (1.1%) higher than in 2019/20, but this is not sufficient to make up for all the missing referrals during the pandemic. It is unclear whether these will show up at some later date. Some local authorities responding to a survey by the DfE reported that, continuing the pre-pandemic trend, the nature of cases coming forward appears to be more complex,* which may add pressures to the system. Analysis from the Nuffield Family Justice Observatory finds that there is a cohort of children with complex needs that are seen as too 'challenging' for secure children's homes, including children with very complex mental health needs.²⁴

There are also some reasons to think that financial pressures resulting from the 2023 cost of living crisis could add to pressure on children's social care. We heard from one interviewee that financial pressures can lead families to cut back on social activities and basic needs like beds and bedding, contributing to mental health issues for children.²⁵ And a 2022 British Association of Social Workers survey of members raised concerns that cost-of-living pressures on families could lead to unmanageable caseloads.²⁶

* Ofsted reports that local authorities use the term 'complex needs' to cover four broad categories of need including mental health needs, behavioural needs that lead to safeguarding concerns, behavioural needs linked to learning difficulties and physical health needs. For further details see <https://socialcareinspection.blog.gov.uk/2023/05/23/children-with-complex-needs-in-childrens-homes>

The number of children on child protection plans remains relatively steady, while the number of children in care has continued to grow

Figure 4.5 Children in care and child protection plans, 2009/10–2021/22



Source: Institute for Government analysis of DfE, 'Characteristics of children in need' ('D4 Child Protection Plans at 31 March by category of abuse and local authority, England 2013 to 2022' table) and 'Children looked after in England including adoption', 2009/10–2020/22 ('CLA numbers and rates per 10,000 children aged under 18 years – LA' table), supported by CIPFA.

The number of child protection plans (CPPs)* rose in 2021/22 for the first time in four years and now stands at around 51,000.²⁷ It is too early to say whether this recent increase is the start of a sustained trend. Ofsted has stated that the increase "is partially due to social workers' cautiousness when considering risks in the context of a new, post-lockdown environment".²⁸

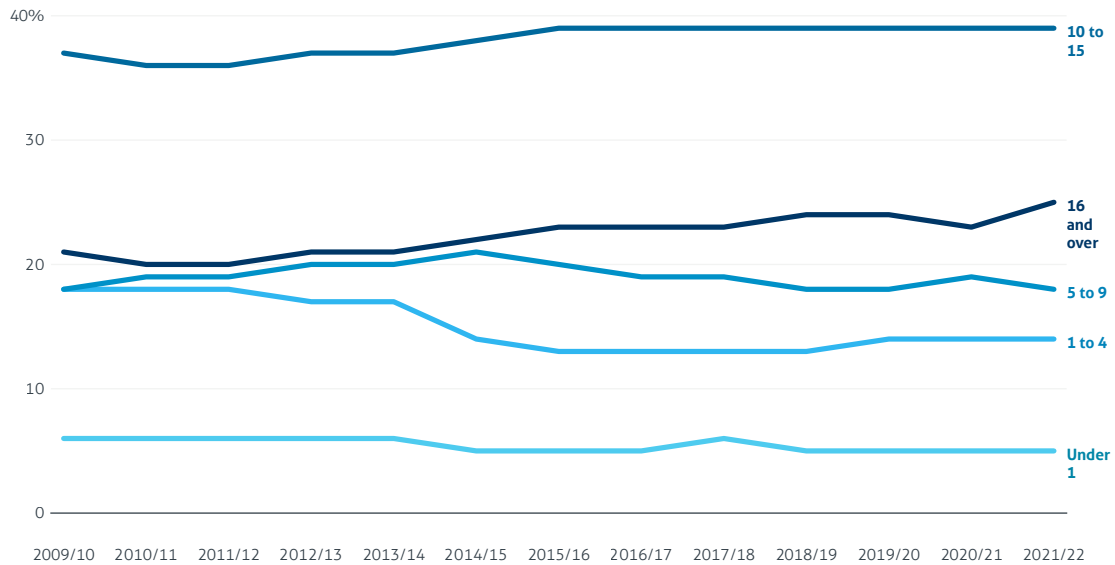
Social workers are now supporting a slightly higher number of children in care.** As of March 2022, there were approximately 82,000 children in care, which was up 1.5% on the previous year and 2.7% higher than in March 2020.²⁹ This continues a longer-term rise seen over the past decade.³⁰ Growth rates are highest for older children, largely due to increases in the number of unaccompanied asylum-seeking children and the length of time children spend in care.***³¹ As a result, older children make up a growing proportion of those in care.

* After a referral, a child may be assessed under section 47 of the Children Act 1989 to be judged at a reasonable risk of harm. If that happens, a CPP is agreed, which commits a local authority to support the child; this plan may cover their care while the child lives with their family or, for example, while they are in residential care.

** A child who has been in the care of a local authority for more than 24 hours. Generally, these children are accommodated in children's homes, residential settings (such as secure units) or with foster parents.

*** The key driver of this trend remains unclear. Multiple explanations have been outlined in DfE, 'Drivers of activity in children's social care' research report, May 2022, accessed September 2022, pp. 7–8, 18–24, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1080111/Drivers_of_Activity_in_Children_s_Social_Care.pdf

Figure 4.6 Children in care by age, 2009/10–2021/22

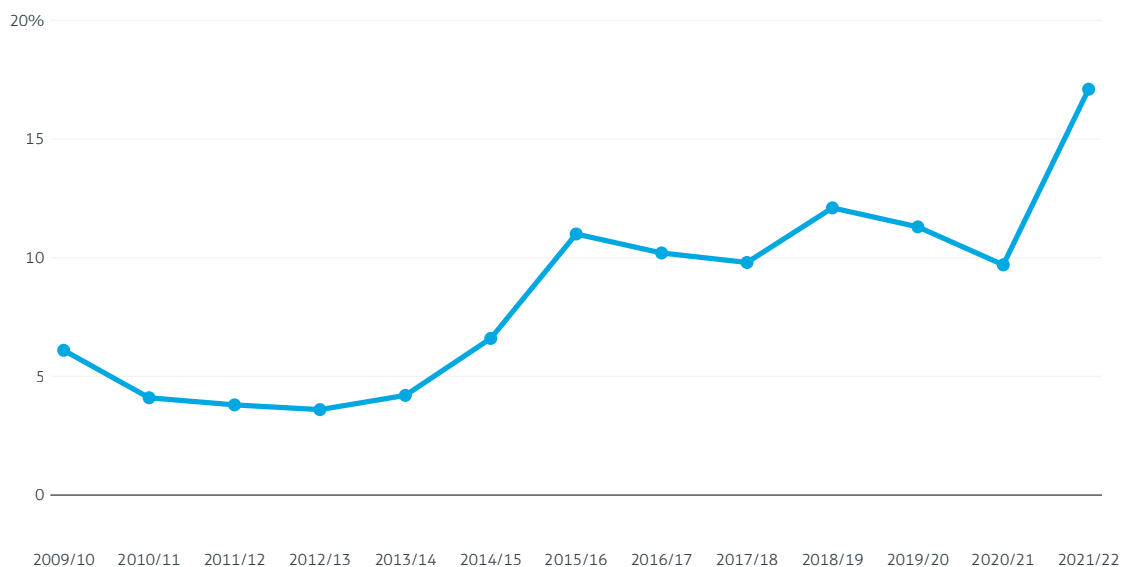


Source: Institute for Government analysis of DfE, 'Children looked after in England including adoption: 2021 to 2022', supported by CIPFA.

There is record demand from current and former unaccompanied asylum-seeking children

The number of children in care who entered the UK as unaccompanied asylum seekers increased by 34.2% to 5,570 in 2021/22 and is now 8.2% higher than the previous peak of 5,150 in 2018/19. Unaccompanied asylum-seeking (UAS) children now account for 17.1% of all children starting an episode of care, the highest on record.³² These children have frequently suffered complex traumas, often linked to the reason for leaving their home countries, travel and occasionally experience of human trafficking; as a result, these children often need additional levels of support from local authorities.³³

Figure 4.7 Children entering care who are unaccompanied asylum-seeking children, 2009/10–2021/22

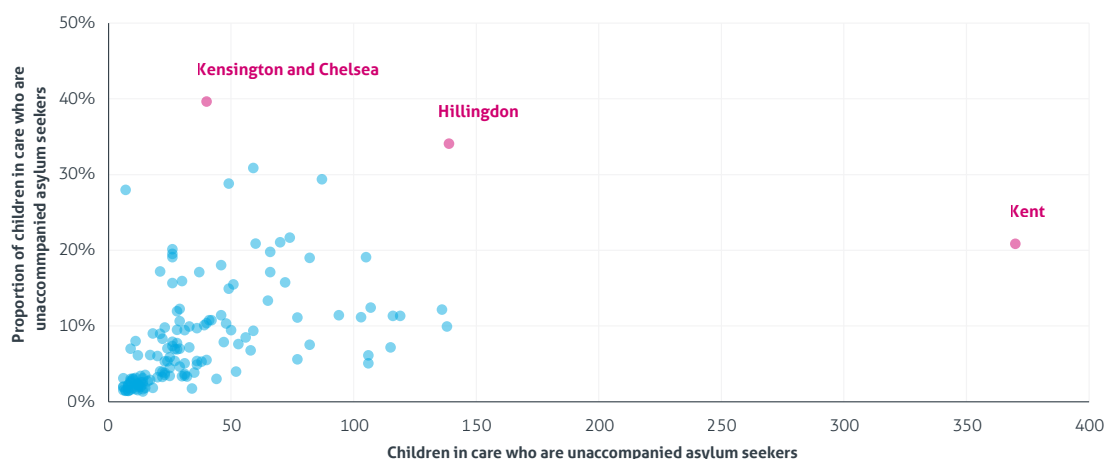


Source: Institute for Government analysis of DfE FOI data (SSDA903) and DfE, 'Children looked after in England including adoptions: reporting year 2022', supported by CIPFA.

Councils are also managing demand from a large number of former UAS children who have subsequently been granted asylum. Between 2010 and 2022, 19,955 UAS children were granted asylum,³⁴ with local authorities supporting 11,650 former UAS children care leavers aged 17–21 as of 31 March 2022.³⁵ Former UAS children now account for 26% of care leavers aged 19–21.

These pressures are not distributed evenly across the country, with some councils facing notably higher pressures.^{36,37} Indeed, for local authorities reporting data as at 31 March 2022, 9% of local authorities' UAS children make up more than 20% of their children in care; with two fifths of children in care in Kensington and Chelsea coming from a UAS children background.³⁸ Notably, Kent County Council has the highest number of UAS children (370), which is more than three times the total number of UAS children in care in the North East (111) and similar to the volume in the South West (387) and Yorkshire and the Humber (349).³⁹

Figure 4.8 **Number and proportion of children in care who are unaccompanied asylum seekers by local authority, 31 March 2022**



Source: Institute for Government analysis of DfE, 'Children looked after in England including adoptions: reporting year 2022' ('CLA on 31 March by characteristics – LA' table), supported by CIPFA. Notes: 15 local authorities were excluded from analysis due to incomplete data returns.

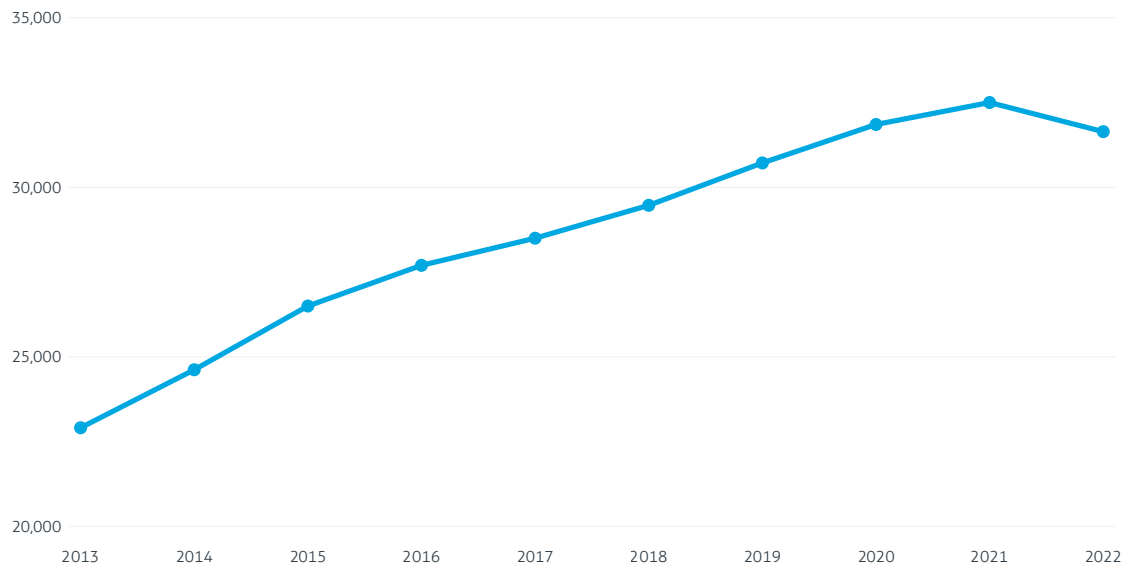
The number of social workers fell in the past year and local authorities have been struggling to fill vacancies

The number of children's and family social workers fell for the first time in a decade, down 2.7% in 2022/23.⁴⁰

This has been due to both increases in staff leaving the workforce and a decline in social workers joining the profession. The number of leavers increased to 5,400 (or 17.1% of the total workforce) in 2022/23 – some 8.5% higher than 2021/22 and the highest number of leavers since comparable data started to be collected in 2013/14.⁴¹ The number of joiners fell to 4,800 in 2022/23 – down 12.5% compared to 2021/22 and the lowest number of joiners since comparable data started to be collected.⁴² This does not reflect a scaling back of jobs for social workers, but rather growing problems in filling the available vacancies.

* Data on UAS children has been withheld in some local authorities due to confidentiality, which may have contributed to relatively low figures for these regions.

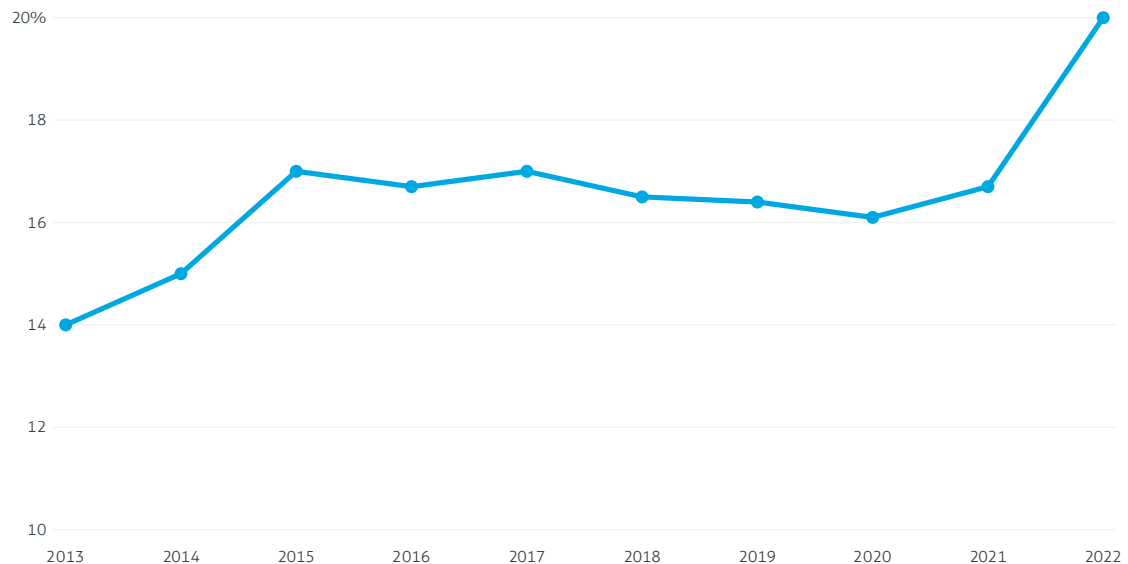
Figure 4.9 Children's social workers (FTE), 2013/14–2022/23



Source: Institute for Government analysis of DfE, 'Children's social work workforce: reporting year 2022' ('Caseloads, absence, vacancies, turnover and agency workers' table), supported by CIPFA. Notes: Following a methodology change, comparable figures are not available before 2013/14. Figures are as at 30 September of the relevant year.

There has been a marked increase in social worker vacancies, which now stand at 7,900 (or 20.0% of the available number of jobs), up 21.3% in 2022/23 and the highest on record.⁴³ More than four fifths of local authorities (83%) when surveyed said that they are struggling to recruit children's social care staff.⁴⁴

Figure 4.10 Children's social worker vacancies, 2013/14–2022/23



Source: Institute for Government analysis of DfE, 'Social work workforce statistics: reporting year 2022' ('Caseloads, absence, vacancies, turnover and agency workers' table), supported by CIPFA. Notes: Following a methodology change, comparable figures are not available before 2013/14. Vacancy numbers are as at 30 September of the relevant year.

A high level of vacancies has made councils increasingly reliant on agency workers: 6,800 agency social workers were in post in 2022/23, up 13.4% on the previous year. As a result, in 2022/23, 17.6% of social workers were agency workers, up from 15.5% in 2021/22.⁴⁵ And even then, these figures are an underestimate. Analysis from the Association of Directors of Children's Services (ADCS) shows a marked increase in the hiring of agency staff on a managed team rather than individual basis.⁴⁶ Services contracted out in this manner are not recorded in agency data.⁴⁷ When services are contracted out this way, local authorities face less flexibility and higher costs.⁴⁸

Combined, these factors have led to council spending on agency workers increasing by 38% over five years.⁴⁹ The impact of problems recruiting and retaining care staff and foster carers was also cited as a problem for social care quality in the recent Competition and Markets Authority investigation.⁵⁰

This high level of churn among social worker also affects children, inhibiting the development of strong relationships with their social worker and adding disruption to their lives.⁵¹

The most important factor in explaining difficulties retaining social workers is high caseloads. Issues related to being overworked were those most commonly cited by people considering leaving their jobs,⁵² and the 2022 British Association of Social Workers annual survey found 52% of social workers were unable to cope with their workload.⁵³ Staff had slightly higher volumes of cases in 2022 compared with either 2020 or 2021. Average caseloads are now somewhat lower than they were immediately pre-pandemic,^{*} but the average caseload of each social worker remains higher than in 2015, with 16.6 cases per social worker in 2022 compared to 15 in 2015.⁵⁴ Furthermore, as noted above, there is evidence that cases have become more complex on average since the pandemic.⁵⁵

Cost-of-living pressures may become an increasingly important factor affecting whether or not people choose to join or stay in the sector. A full and final £1,925 pay offer to all local government employees, including social workers, has been rejected and three unions are balloting for industrial action. We have also heard that service providers are struggling to retain early help practitioner roles^{**} due to competition from the retail sector,⁵⁶ which can often offer higher wages.⁵⁷ Up to 2019/20, social worker real-terms median social worker wages had fallen by 9.5% against 2009/10 levels and though this improved over the pandemic, real-terms median wages in 2021/22 were still 4.5% below 2009/10 figures.⁵⁸

* The average caseload for 2019 was 16.9 cases per social worker, 17.4 cases per social worker in 2018 and 17.8 cases per social worker in 2017. For further details see <https://explore-education-statistics.service.gov.uk/find-statistics/children-s-social-work-workforce/2022>

** Early help practitioners support families to overcome issues and build their strengths.

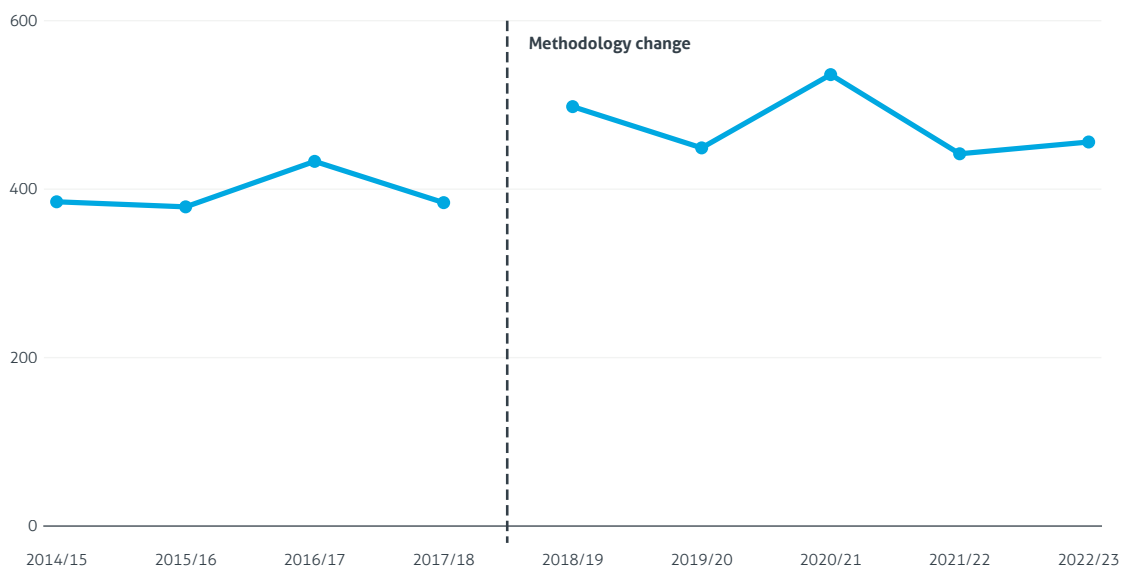
The quality of children's social care appears relatively stable

Regular inspections of children's services were suspended during the pandemic, but these were resumed from 12 April 2021, which means we have a snapshot of service performance for some local authorities as they exited the pandemic. According to this, there has been an improvement in assessed compliance with inspected standards. Of the 74 inspection reports published by Ofsted between 2020/21 and 2022/23, over half were rated as outstanding or good (55.4%). Of the 40 full inspections that have been carried out since 31 March 2021, a total of 23 authorities were rated to be performing better than they had been pre-pandemic, while nine declined and four stayed at the same grade.⁵⁹ As of March 2023, some 90 authorities are rated good or outstanding (59.2%), 48 are requiring improvement (31.6%) and 14 are inadequate (9.2%), though many of these ratings are based on assessments that predate the pandemic.⁶⁰

Another indicator of service quality is the number of serious incident notifications. Local authorities are required to send these to Ofsted when a child who was known to be at risk has died or come to harm. In 2022/23, there were 456 of these notifications, up 3% on 2021/22 and similar to the volume of cases seen in 2019/20.⁶¹ It is too early to judge whether these figures will rise further in future years, given the increase in referrals.

There has been considerable public scrutiny of children's social care following the tragic deaths of Arthur Labinjo-Hughes and Star Hobson, which led to a national inquiry into their deaths.^{62,63} In both cases social care service provision was affected by pandemic-era restrictions. While the findings of the national inquiry have informed the government's plans to reform social care, other harrowing lockdown cases continue to progress through the courts, including the murder of Finley Boden, whose case appeared before the courts in May 2023.⁶⁴

Figure 4.11 **Serious incident notifications, 2014/15–2022/23**



Source: Institute for Government analysis of DfE, 'Serious incident notifications' ('All year totals' table), 2022/23, supported by CIPFA. Notes: Data is only available from 2014/15 onwards. This notification criteria for local authorities to report serious incidents changed in July 2018.

* A further two authorities were assessed for the first time. Two more cannot be compared due to the merging of council boundaries.

The independent review of children’s social care, published in May 2022, called for a radical change in services to make them more responsive, respectful and effective.⁶⁵ The review called for changes to working practices and processes, as well as reform of the children’s social care market.⁶⁶ Echoing similar calls from the children’s commissioner,⁶⁷ it also called for children’s voices to be better heard when decisions are made on their care packages.⁶⁸ Local authorities would need more funding to enact all these recommendations.

The government launched its response in February 2023, outlining ambitions for change in the sector and opening several consultations.⁶⁹ While the government’s response was broadly welcomed by the sector,⁷⁰ the government has been criticised for the small scale and slow pace of change,⁷¹ and for providing only 20% of the funding called for by the independent review.⁷² The House of Lords Public Services Committee recently criticised the government’s strategy for a lack of engagement from relevant departments across Whitehall, its lack of funding and its limited discussion of the issues facing the residential care market.⁷³

5. Neighbourhood services



Neighbourhood services: key figures

- **£18.6bn** – the total amount spent on local authority services, excluding adult social care and children’s services, in 2021/22. This is 3.5% lower than in 2020/21 and 30.6% lower than in 2009/10.
- **Nine** – the number of section 114 notices issued since 2020, effectively declaring a local authority bankrupt, compared to three in the previous 20 years.
- **104,510** – the number of households in temporary accommodation as of Q1 2023, up from 51,310 in 2010.
- **41.5%** – the proportion of waste sent for recycling in 2021/22, below the government’s target (set for 2020) of 50%.
- **£14.0bn** – the combined maintenance backlog across the local authority road network.
- **73%** – the proportion of people who are satisfied or very satisfied with their local area, the lowest level in a decade.

Introduction

Neighbourhood services – libraries, planning, bus subsidies, road maintenance, homelessness, public health, and waste collection, disposal and recycling – had been radically cut back before the pandemic following a decade of funding cuts.*

Since the pandemic, spending on these services overall has increased but new pressures have been placed on some of them by high inflation and falling living standards in local populations. These pressures have fallen harder on some groups and in some parts of the country than others, with a knock-on effect on the change in demand for different services in different local authorities.

Overall, demand for libraries and the need for support of homeless people have grown. By contrast, demand for bus travel has yet to fully recover, challenging the commercial viability of the current funding model. Limited progress has been made in reducing the backlog of road maintenance or planning applications and there has been little meaningful change in the proportion of waste that is being recycled.

* This year *Performance Tracker* has been rescoped to focus on services that account for a higher proportion of neighbourhood services spending. We no longer track food safety, health and safety, and trading standards, which accounted for £0.29bn of expenditure in 2021/22. Instead, we now additionally monitor local authority homelessness, bus subsidy and public health services, which accounted for £7.23bn of expenditure in 2021/22.

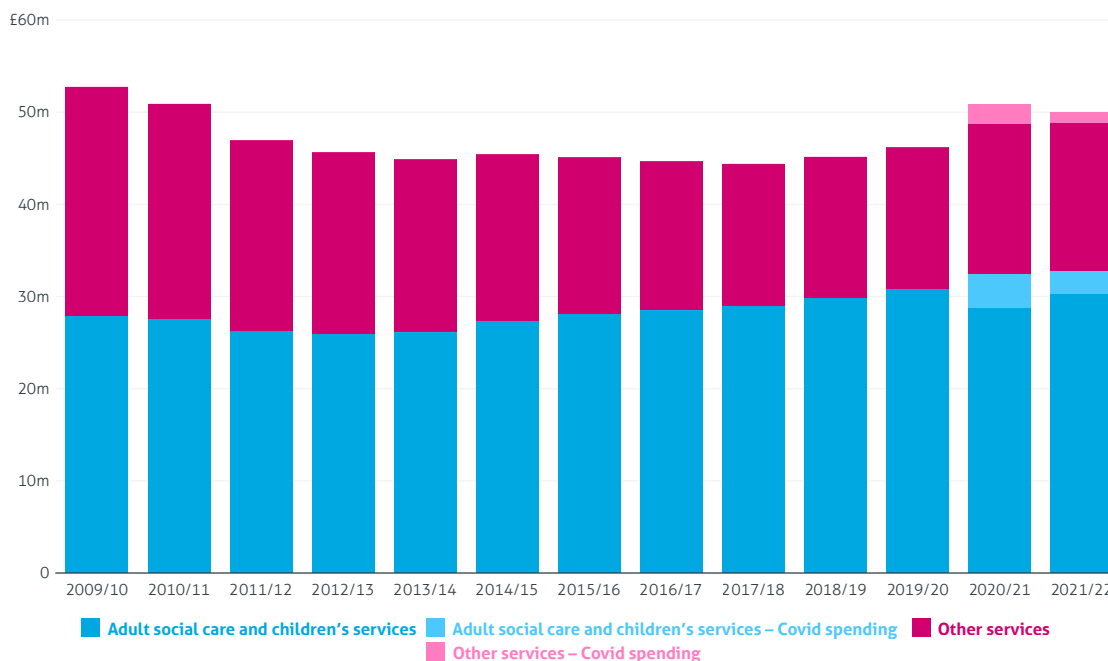
Meanwhile, the picture in public health is mixed, with some increasing demands from sexual health services and alcohol misuse services while proportionately fewer children are being seen through early years health programmes.

Given the pressures on local authority workforces, including dissatisfaction with pay and the loss of around a quarter of staff over the past decade, local authorities may struggle to improve service performance and address the falling satisfaction with councils and local areas. The ability of individual local authorities to address these problems will depend on a variety of factors, including funding levels, demographic demands and the quality of governance.

In this chapter we cover local authority provided services in England.

Overall spending on neighbourhood services fell in 2021/22, but there is substantial variation between services

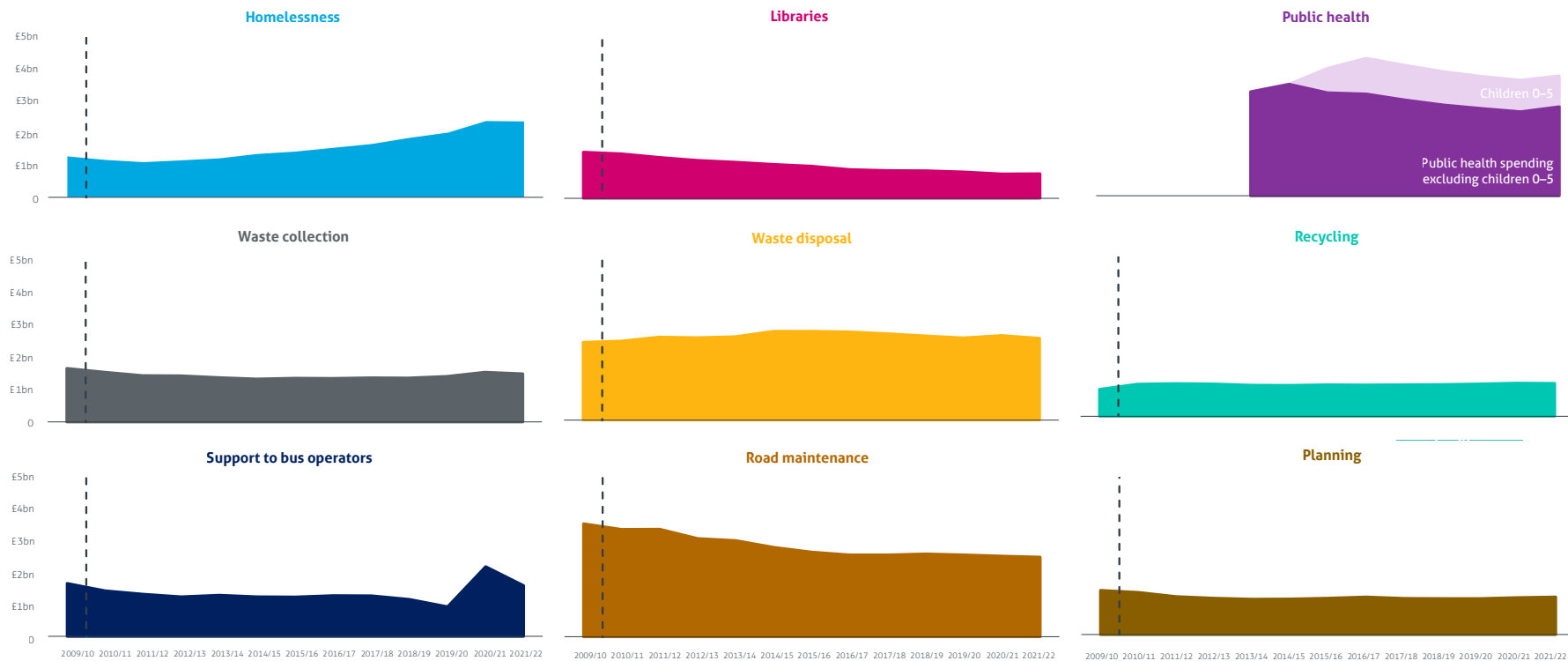
Figure 5.1 Local authority spending, 2009/10–2021/22 (2023/24 prices)



Source: Institute for Government analysis of DLUHC, revenue outturn accounts 2009/10–2021/22 and DLUHC, 'Local authority Covid-19 financial impact monitoring information, rounds 1-20', 12 August 2022, supported by CIPFA. Notes: Figures relate to expenditure net of self-generated income and are not directly comparable with other figures in this chapter. Responsibilities for Sure Start moved to children's services in 2014/15 – these make up approximately 4% of social care spend in 2021/22. See Methodology for details of how figures have been put into 2023/24 terms.

In the decade before the pandemic, successive governments cut local authority grant funding, while demand for adult and children's social care – covered in earlier chapters – and other statutory duties (such as homelessness services) continued to rise. These pressures forced councils to cut back funding for non-statutory services, making tough decisions about where the cuts should fall.¹ Overall, local authority spending on services excluding adult social care and children's services declined by 38.2% in real terms between 2009/10 and 2019/20. With the onset of the pandemic,

Figure 5.2 Local authority spending on neighbourhood services, 2009/10–2021/22 (2023/24 prices)



Source: Institute for Government analysis of DLUHC, revenue outturn, 2009/10–2021/22, supported by CIPFA. Notes: Financial responsibility for public health was delegated to local authorities in 2013. Figures on 'Test, track and trace and outbreak planning' and 'Other public health spend relating to COVID-19' have been excluded from public health figures presented here. Figures reported in this analysis are gross expenditure. Figures for 2009/10 are not directly comparable with other values due to an accounting treatment for capital approximating to 1.5% of expenditure – for further details see Methodology. See also Methodology for details of how figures have been put into real terms.

local authorities' expenditure increased by 20.5% in 2020/21 as they took on new responsibilities. Funding then fell by 3.5% in 2021/22, from £19.9bn to £18.6bn. As a result, local authority spending on non-social care services was 12.3% higher than in 2019/20 but still 30.6% lower than in 2009/10 – though when emergency Covid spending is removed this equates to a 35.1% reduction.

The relatively small spending decrease in the last year hides variation between services. Like other statutory duties, spending on homelessness had markedly risen in the past decade and is now 82.6% higher in real terms than in 2009/10. However, spending in this area fell 0.4% in 2021/22.

The greatest decline was seen in support to bus operators, which fell by 27.3% in 2021/22 compared to 2020/21, yet it remains 70.9% higher in real terms than before the pandemic. This is due to continuing support to bus operators, who, though performing more strongly than in 2020/21, remain reliant on high levels of financial support to maintain services in the face of lower passenger numbers.²

Smaller declines were seen in waste collection and disposal, both of which declined 3.3% in real terms – though spending is still 5.8% higher than pre-pandemic levels for waste collection, a reflection of the increased volume of activity seen during the pandemic. The amount spent on road maintenance also declined by 1.3% in 2021/22, and it is now 2.7% below pre-pandemic spending.

Like waste collection, planning work continued throughout the pandemic with social distancing less of a concern. Indeed, planning spending in 2021/22 is 4.4% higher in real terms than in 2019/20, increasing in both 2020/21 and 2021/22.

The service with the greatest spending increase in 2021/22 was public health (excluding 0–5 year-old children's spend),* which grew by 5.9% due to higher service demands and costs across most public health areas. As a result, spending is now 2.0% higher than in 2019/20. Meanwhile, spending on libraries flatlined, increasing by only 0.8%. This remains 6.9% lower than before the pandemic, and almost 50% lower than in 2009/10.

Neighbourhood services budgets remained tight in 2022/23 and 2023/24

Data on local authority spending in 2022/23 will not be published until December. However, it is likely that budgets were even tighter for these services in 2022/23 than the year before due to changes to the national living wage and high inflation and energy costs.³ For example, road maintenance has been affected by energy-linked maintenance costs for signage and street lighting,⁴ with 70% of local authority respondents to an Asphalt Industry Association (AIA) survey reporting unforeseen costs in 2022/23, up from 56% of respondents in 2021/22.

In the 2022 autumn statement the government outlined several measures to alleviate financial pressure on councils in 2023/24 and 2024/25⁵ – full details of which are outlined in the 'Adult social care' chapter.

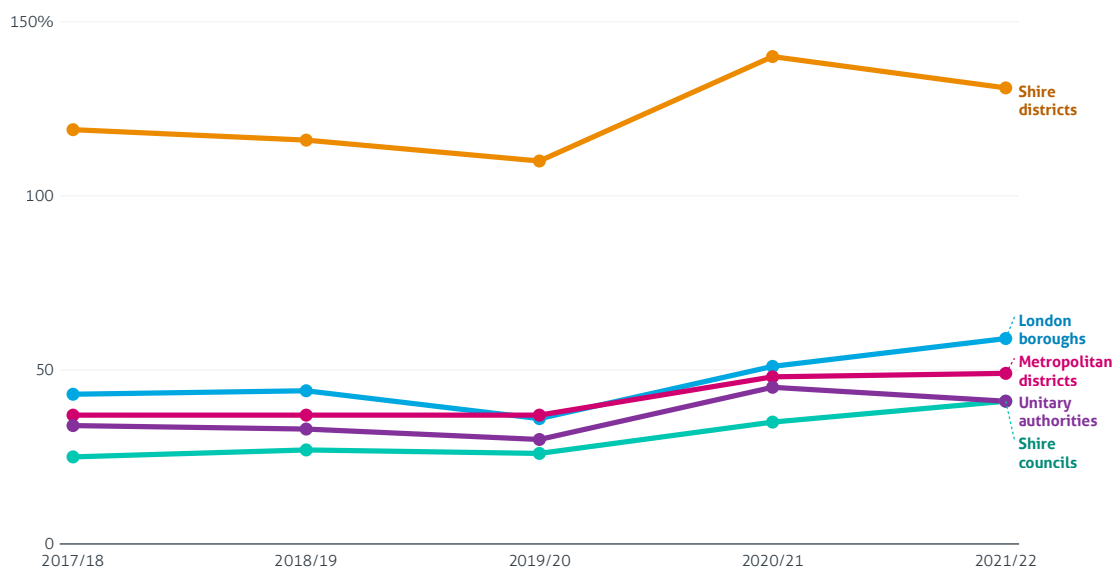
* Public health figures throughout the chapter excludes public health spend on the Covid-19 response.

The December 2022 local government finance settlement confirmed a £5.1bn increase in core funding for 2023/24, comprising a mix of £2.2bn of social care grants, £1.7bn of other grant funding* and £2.0bn of assumed additional council tax revenue.** Inflation, though, has both overshot and lasted longer than spending plans assumed. Local authority budgets have been further squeezed by changes to minimum wages, which – as the adult social care chapter shows – have brought an additional £1.8bn funding pressure in the adult social care sector in 2023/24. Similar costs are expected for the local government wage bill.⁶

While the situation will vary between local authorities, analysis from the Local Government Association (LGA) published in July 2023 suggests that councils will exceed core funding by £2bn in 2023/24 and £0.9bn in 2024/25. An interviewee told us that budget pressures will force the council to use reserves as a stop gap while they scale back the services they provide to the public.⁷

Reserves are likely to have increased during the pandemic, but the precise level remains difficult to determine

Figure 5.3 Median un-ringfenced reserves as a percentage of service expenditure, by local authority type, 2017/18–2021/22



Source: Institute for Government analysis of DLUHC, 'Local authority General Fund earmarked and unallocated reserves, England 2018 to 2022' ('Medians' table), 18 May 2023, supported by CIPFA. Notes: DLUHC has adjusted these figures to remove distortionary effects linked to the timing of emergency Covid grants including business rate reliefs. For further details, see Methodology.

Despite expectations that reserves would fall during the pandemic,⁸ usable reserves in England as a proportion of expenditure increased on average in 2020/21 across all categories of local authority. While, on average, usable reserves as a percentage of expenditure fell in unitary authorities and shire districts in 2021/22, this was not the case across other categories of local authority and on average all five types held proportionately higher levels of reserves in 2021/22 than in 2019/20. However, the precise numbers are sensitive to accounting adjustments required to compensate for

* Including the Revenue Support Grant and retained business rates.

** These were in part offset by £0.9bn of services and other grants. For further details see <https://researchbriefings.files.parliament.uk/documents/CBP-9721/CBP-9721.pdf>, p. 10.

the timing of emergency business rate reliefs disbursed early in the pandemic. And, as one interviewee pointed out, latent issues with data returns from councils may mean some councils' reserves are currently overstated and it may be several years before these can be properly identified.⁹

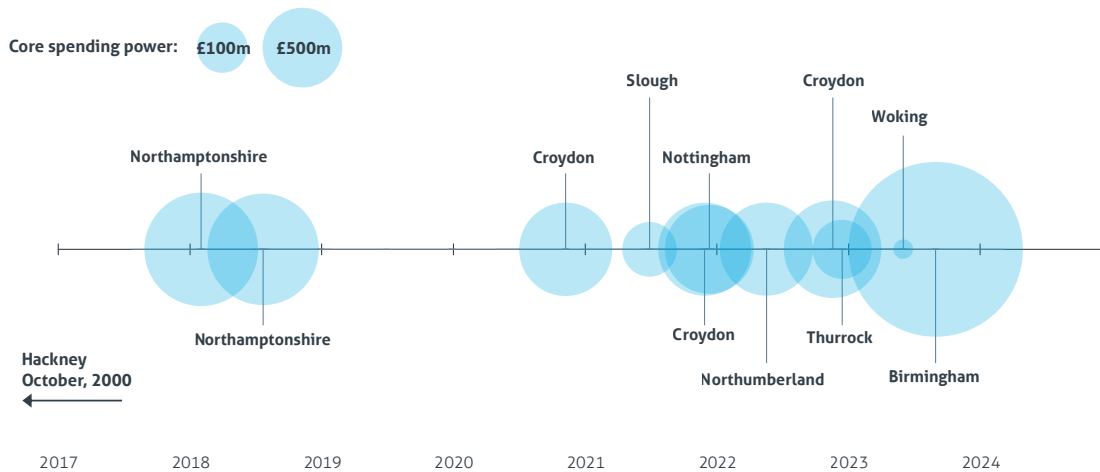
Government ministers have been critical of councils for holding 'baffling' levels of reserves.¹⁰ And the rapid increase in reserves during the pandemic will, in some councils, relate to unspent Covid grants. However, increasing reserves is a rational decision when facing greater uncertainty around funding and in the broader external environment. Furthermore, arguing that councils should deplete reserves to finance day-to-day expenditure runs against good financial management practice.¹¹ Finally, while at a national level reserves increased in 2021/22, the situation varies considerably at a local level. Some councils, like Bradford, are warning that their reserves are running low¹² and a survey of 116 local authority draft accounts suggests usable reserves for unitary authorities and London borough authorities were depleted by 18% and 17% respectively in 2022/23.¹³

Some councils with risky investments have declared 'bankruptcy' but financial problems are more widespread

In the past year, several local authorities, including Croydon,¹⁴ Thurrock¹⁵ and Woking,¹⁶ issued section 114 notices – effectively declaring themselves bankrupt¹⁷ – after large losses on investments.

Following cuts to local government grants, these local authorities sought alternative revenues through large-scale investments, financed by loans, often in commercial property.¹⁸ But several councils are now highly leveraged and in its recent *Fiscal Risks and Sustainability* report the OBR identified the £96bn borrowed by the local authority sector as a risk to public finances.¹⁹ Covid led to reduced demand for commercial property and recent interest rate rises have increased financing costs, affecting the commercial viability of these investments and leaving some councils highly exposed.²⁰ Additionally, in early September 2023, Birmingham City Council filed a section 114 notice due to issues with the valuation of an earlier equal pay settlement,²¹ and was reported to be considering issuing a second section 114 notice linked to a lack of urgency about the speed of responding to the equal pay settlement.²²

Figure 5.4 **Section 114 notices, 2017–2023, as at 31 October 2023 (2023/24 prices)**



Source: Institute for Government analysis of various sources, including local authority press releases and media reports. Notes: Section 114 notices for Nottingham and Northumberland were issued as a result of unlawful expenditure, as opposed to being unable to balance their budget.

The recent sharp rise in interest rates may also affect the viability of other capital finance projects, such as building renovations, the construction of new council offices or upgrading library facilities.^{23,24} These issues have contributed to the financial pressures that local authorities are under more generally. While the impact varies across local authorities, only 14% of senior council leaders are confident in the sustainability of their authority. More than 90% expect to increase taxes and increase fees for services, more than 50% will be cutting spending, and more than 70% expect to deplete 'rainy day' financial reserves.²⁵ The struggle to meet day-to-day spending has increased the likelihood of other section 114 notices.²⁶ For example, high use of temporary accommodation has left Hastings Council vulnerable to a section 114 notice.²⁷ Indeed, a survey of 47 urban local authorities found that 10% of its members may issue a section 114 notice this year and 20% may need to next year.²⁸

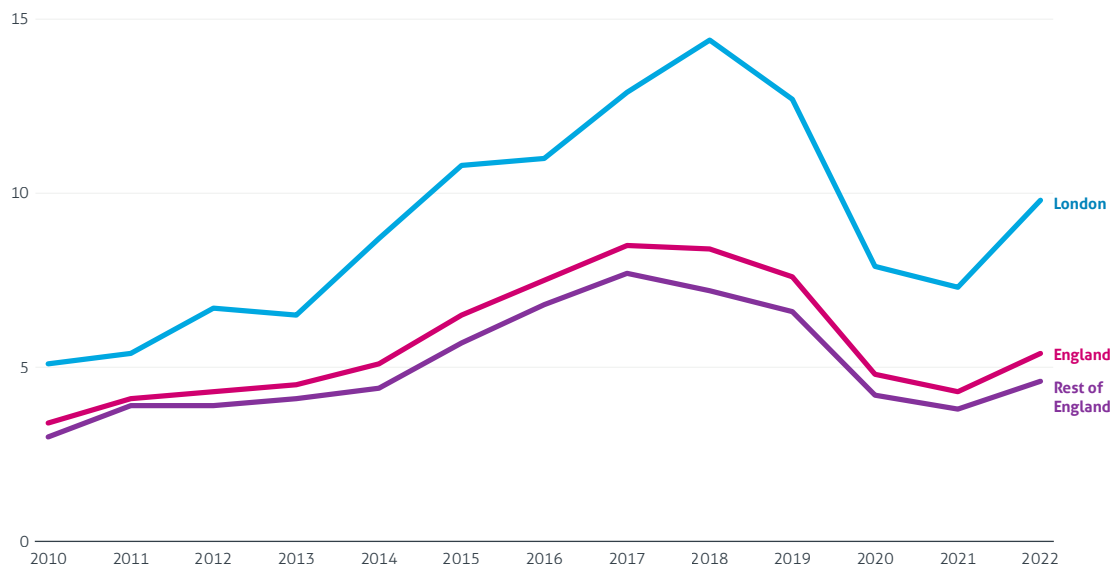
Homelessness increased in 2022 and councils are struggling to find appropriate accommodation

Based on estimates from the Department for Levelling Up, Housing and Communities, there were 3,069 people sleeping rough in autumn 2022,* a 25.6% increase on the 2,443 estimated in 2021, though 28.1% below the 4,226 estimated in 2019.²⁹ This estimate is, however, a snapshot of one night in October. Estimates based on the Greater London Authority CHAIN dataset suggest a total of 10,053 rough sleepers in London during the 2022/23 financial year, which was 21% higher than in 2021/22.³⁰ This data also suggests that 6,391 people were seen sleeping rough for the first time in London in 2022/23.³¹

Part of the increase in rough sleeping over the past year may be linked to the ending of pandemic emergency measures such as controls on evictions and the 'Everyone In' programme, through which 9,866 people were put into hotels and emergency accommodation and 23,273 were moved into more settled accommodation by November 2020.³²

* The department estimates the total number of people sleeping rough on a given night in autumn. Further details on methodology can be seen here: <https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2022/rough-sleeping-snapshot-in-england-autumn-2022>

Figure 5.5 **People sleeping rough per 100,000 population, 2010–2022**



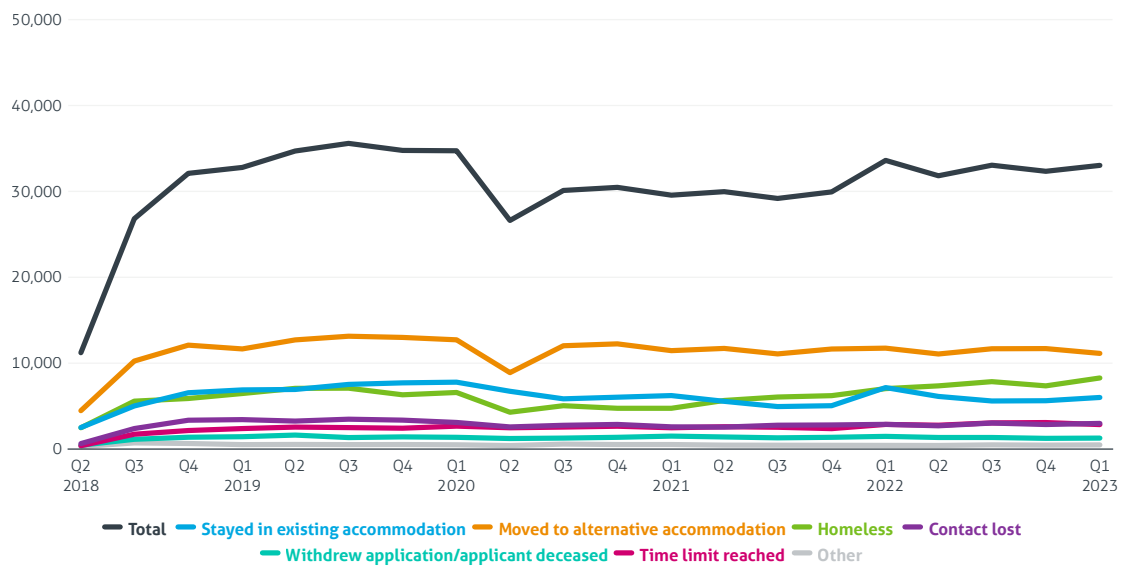
Source: Institute for Government analysis of DLUHC, 'Rough sleeping snapshot in England: autumn 2022', supported by CIPFA. Notes: Local authorities estimate this figure for a single night in autumn between 1 October and 30 November.

The official estimates of homelessness are smaller than those calculated by others. The homelessness charity Crisis defines homelessness more broadly to include unconventional accommodation (for example, cars), hostels, unsuitable temporary accommodation and sofa surfing.^{33,34} Based on this broader definition, Crisis estimates that approximately 242,000 households were homeless in 2022, up from 224,000 in 2018 and 206,000 in 2012.³⁵

Overall, it does appear that there has been a long-term increase in the number of households unable to afford accommodation.³⁶ This is due to a combination of factors including freezes to the local housing allowance,^{*,37,38} a reduction in available rental properties contributing towards higher rents³⁹ and the broader cost-of-living crisis.

* The local housing allowance (LHA) is a process for determining housing benefits for those renting from a private landlord – this is based on the number of bedrooms required for the claimant.

Figure 5.6 Households for whom homelessness prevention duty ended, by reason, Q2 2018 to Q1 2023

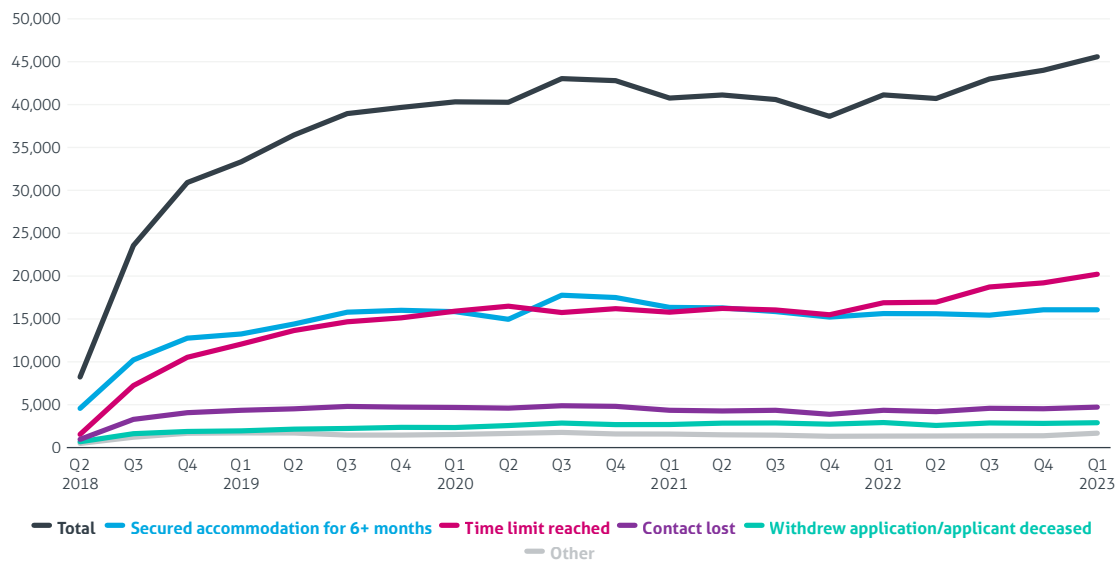


Source: Institute for Government analysis of DLUHC, 'Statutory homelessness in England: January to March 2023', supported by CIPFA. Notes: Data on prevention duties only started in April 2018 with the introduction of Homelessness Act Reduction duties. Figures at the start of the data series may be under-reported, as local authorities implemented the legislation and familiarised themselves with reporting mechanisms. Figures for homeless include intentionally homeless. 'Time limit reached' is where 56 days elapsed with no further action.

Local authorities' homelessness services appear to have struggled to keep up with higher demand over the past year. For example, the proportion of those securing suitable accommodation for more than six months fell from 39.0% in 2021/22 to 36.5% in 2022/23. Meanwhile, the proportion of those whose relief duty* has ended after 56 days without securing suitable accommodation rose from 40.0% to 43.4% over the same period. Under these circumstances, when 56 days have elapsed, the local authority's duty relief to 'homeless' applicants ends⁴⁰ and, instead, applicants are characterised as a priority need for long-term council accommodation, receiving temporary accommodation in the short term.⁴¹

* Since the passage of the Homelessness Reduction Act (2017), local authorities face an obligation to work to relieve homelessness for all eligible applicants who become homeless. For further details see <https://researchbriefings.files.parliament.uk/documents/SN01164/SN01164.pdf>

Figure 5.7 **Households for whom homelessness relief duty ended, by reason, Q2 2018 to Q1 2023**



Source: Institute for Government analysis of DLUHC, 'Statutory homelessness in England: January to March 2023', supported by CIPFA. Notes: Data on relief duties only started in April 2018 with the introduction of Homelessness Act Reduction duties. Figures at the start of the data series may be under-reported as local authorities implemented the legislation and familiarised themselves with reporting mechanisms. 'Time limit reached' is where 56 days elapsed with no further action.

The use of temporary accommodation has increased by 104.7% (more than doubled) since 2010 and now stands at 104,510 households,⁴² up from 51,310.⁴³ This is the highest use of temporary accommodation since 1998 and follows a 4.0% increase in the last quarter and a 10.0% increase over the past year.⁴⁴ According to one interviewee, housing teams are competing with children's services and immigration teams for appropriate private sector accommodation, driving up costs.

Demands on library services increased during the past year

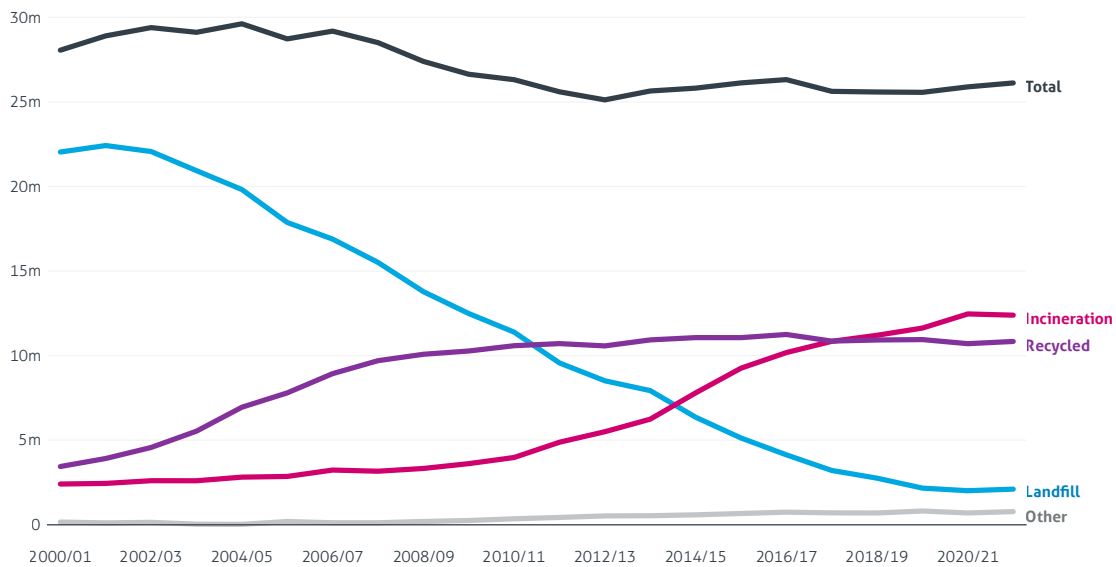
Despite a continuing reduction in library spending, demands on these services are increasing. Libraries saw a 68% increase in footfall between 2020/21 and 2021/22 as lockdowns lifted and people opted for more in-person services. This could also be linked to a shift in where people access services – as people return to centralised library sites which co-locate with other public services, such as Jobcentre Plus, GP surgeries⁴⁵ and theatres.⁴⁶ These centralised library sites experienced the largest reductions in footfall during the pandemic, as visitors went to smaller local branches.⁴⁷ Yet with fewer facilities on offer, small libraries attracted a relatively smaller footfall, and contributed to lower overall footfall during the pandemic.⁴⁸

It is too early to tell the full impact of inflation on libraries but there is evidence it may have increased demand. According to a survey of 3,000 parents in December 2022, 20% reported buying fewer books for children due to cost-of-living pressures, a figure that rose to 1 in 3 among parents that reported struggling financially, with 28.2% of parents borrowing more children's books from libraries.⁴⁹

Demand for other library services may also have increased, with 81% of libraries surveyed in June 2022 anticipating higher footfall in order to access warm spaces.⁵⁰ By that time, 59% of libraries had seen an increase in people attending events and staying for the rest of the day and 44% of libraries had already experienced increased demand for services to help with the cost-of-living crisis.⁵¹ Relevant services provided by libraries include food, clothing and hygiene banks, access to price comparison websites, personal budgeting classes and workshops, and help with applying for and managing Universal Credit.

Waste collection, disposal and recycling levels have been stable in the past year

Figure 5.8 Tonnes of waste disposed of by local authorities, 2009/10–2021/22



Source: Institute for Government analysis of Defra, 'ENV18: Local authority collected waste generation from April 2000 to March 2022 (England and regions) and local authority data April 2020 to March 2022' ('Table 1a'), supported by CIPFA.

The amount spent on waste collections and disposals decreased slightly in 2021/22 – both falling by 3.3% in real terms – but the volume of waste disposals increased by 0.9% over the year. The proportion of household waste that was sent for recycling remained almost unchanged at 41.5% in 2021/22, up from 41.4% in 2020/21, which was the lowest level since 2011/12. The year 2021/22 was also the fifth in a row that incineration exceeded recycling as the most used method of waste disposal, with 47.4% of waste being incinerated. The government has still yet to meet its target (originally set for 2020) of 50% recycling and an assessment from the Climate Change Committee suggests it is off course for meeting the 65% recycling target by 2035.⁵²

While the government missed its target for recycling of household waste, it exceeded its 2020 target to reduce the amount of biodegradable municipal waste (BMW) sent to landfill.⁵³ The government has set itself a net zero strategy target of eliminating BMW, including food waste, sent to landfill by 2028.⁵⁴ However, it may struggle to meet this, with the amount of BMW being sent to landfill increasing by 8% in 2021.

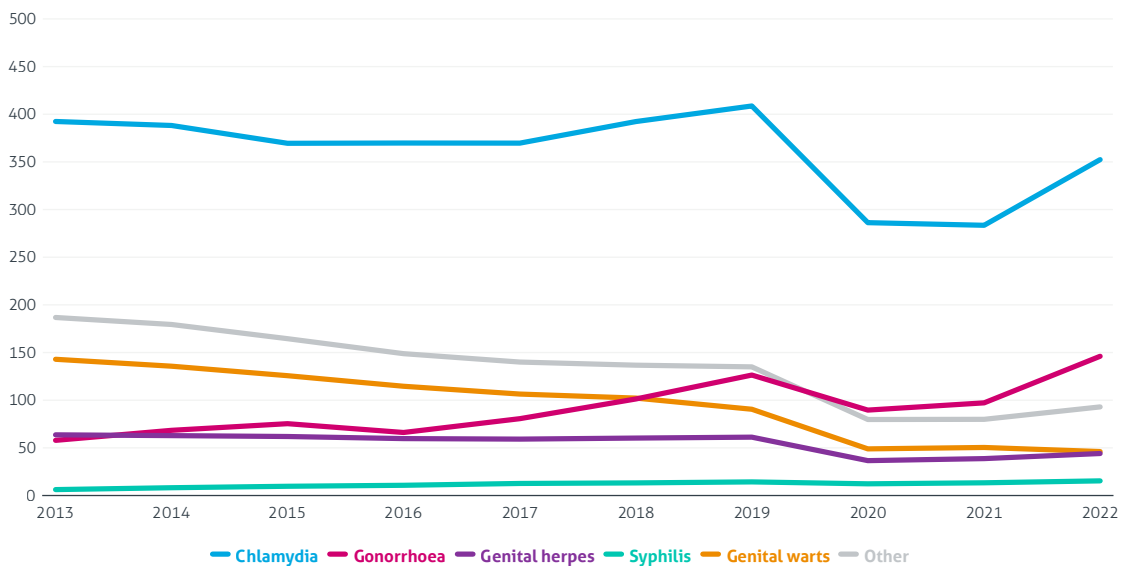
Public health

In April 2013, responsibility for public health transferred to local authorities, including a duty to improve public health and the provision of certain public health services.⁵⁵ In exercising these responsibilities, local authority public health teams collaborate with local partners to improve health outcomes and commission services directly.⁵⁶ However, the full range of public health interventions – including local authority measures targeting health and life expectancy – is difficult to assess. We therefore evaluate three services within public health where output metrics allow clearer assessment of local authority performance: sexual health services, substance misuse and children’s early years health programmes.*

Sexual health services – sexually transmitted infection (STI) rates are up due to society reopening and increased testing

Spending on STI testing and treatment increased by 4.0% in real terms between 2020/21 and 2021/22 to £377.8m (in 2023/24 terms). However, it remains 3% below spend in 2019/20 and 28% below 2013/14 levels. Other sexual health services have also markedly reduced over this period, with funding for contraception falling by 24% and spending on advice, prevention and promotion falling by 45% since 2013/14.

Figure 5.9 Sexually transmitted cases per 100,000 population, 2013–2022



Source: Institute for Government analysis of UKHSA, ‘Sexually transmitted infections (STIs): annual data tables’ (‘Table 1: new STI diagnosis numbers and rates in England by gender’), 2013 to 2022, supported by CIPFA. Notes: Figures for syphilis cover the primary, secondary and early latent stages, while figures for genital warts and herpes relate to a first episode.

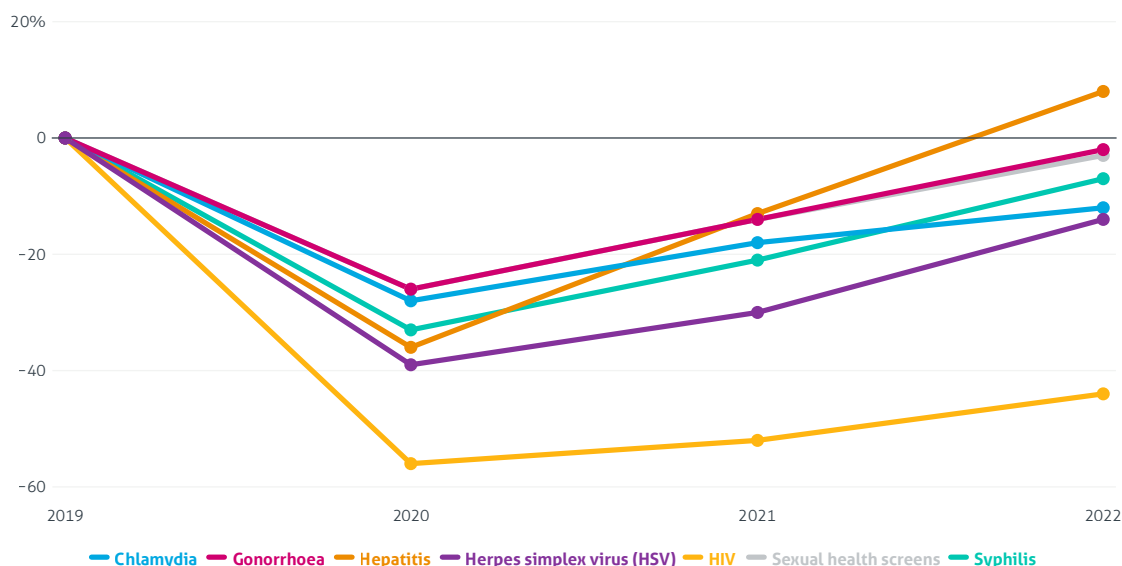
The recorded incidence of most STIs is up from pandemic-era lows but remains below pre-pandemic highs.** The STI with the highest observed prevalence in the public is chlamydia, of which there were 352.4 cases per 100,000 in 2022, up 24% on 2021, though still below 2019 levels.⁵⁷ A similar pattern can be seen for herpes (44 cases per 100,000) and other genital warts (46 cases per 100,000). However, rates of both

* The services discussed in this chapter represent a subset of services from the largest public health spending areas.

** Data on the testing, diagnosis and care outcomes related to HIV and PrEP uptake are reported separately online at <https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2022-report>

gonorrhoea and syphilis are now above 2019 levels, reaching 146 per 100,000 people and 15 per 100,000 respectively – in each case, the highest rate since comparable records began in 2013. Increasing STI identification has contributed to an increase in the need for sexual health services to notify the partners of people with STIs across almost all STI categories. Overall, the number of partner notifications grew from 79,805 in 2021 to 90,984 in 2022.⁵⁸

Figure 5.10 **Change in number of sexually transmitted infection tests since 2019**



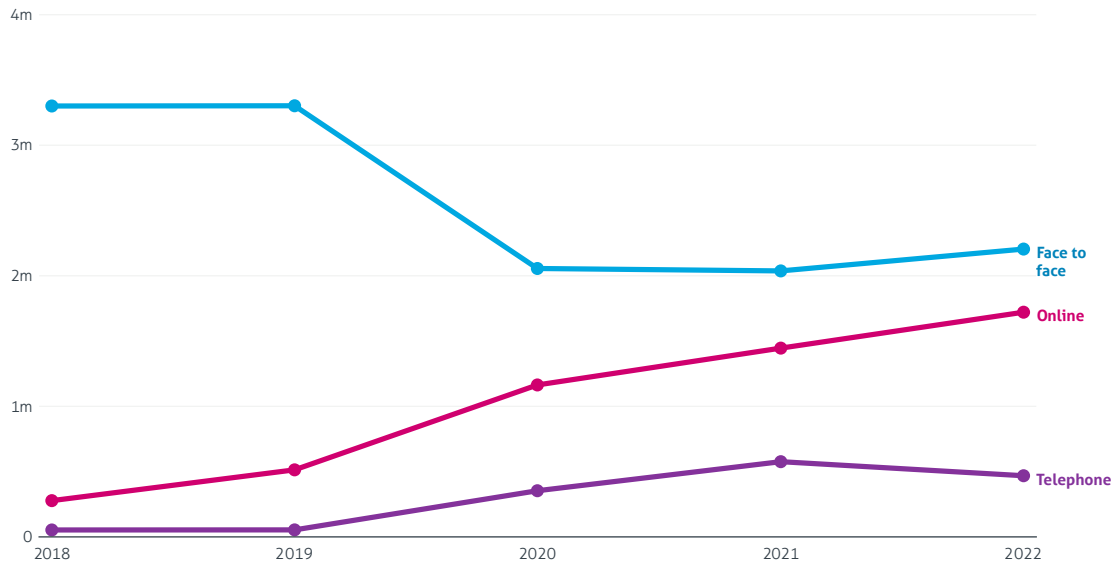
Source: Institute for Government analysis of UKHSA, 'Sexually transmitted infections (STIs): annual data tables' ('Table 4: all STI diagnosis and service number in England and regions by gender and sexual orientation'), 2019 to 2022, supported by CIPFA. Notes: 'Hepatitis' covers hepatitis A, B and C. Sexual health screens may include any combination of one or more tests for chlamydia, gonorrhoea, HIV or syphilis.

The overall trend has likely been driven by the lifting of pandemic-era social distancing restrictions and the reopening of many sexual health services that were closed during 2020. The higher recorded STI rates may also be in part attributable to more testing, which increased as services reopened.* Between 2020 and 2022 the volume of testing increased for chlamydia by 22%, gonorrhoea by 32%, hepatitis A, B or C by 69%, syphilis by 39% and HIV by 25%. These increases have not been enough to fully reverse the marked declines seen during the pandemic and testing for most STIs remains below 2019 levels, most notably HIV testing, which has fallen by more than 40%. Consequently, STI caseload data may underestimate the prevalence of some STIs currently in the community.

While the number of tests conducted has fallen, local authorities are now delivering more STI consultations than ever – up from 3.9 million to 4.4 million between 2019 and 2022. This is largely due to the shift to online consultations, which increased from 0.5 million consultations in 2019 to 1.7 million in 2022. This more than offset the decline in face-to-face consultations, which fell from 3.3 million to 2.2 million over the same period.

* While increasing volumes of STI testing were delivered in this time, sexual health services were redeployed in response to the emergency roll-out of mpox vaccines during 2022, which may have limited access to STI testing in some areas.

Figure 5.11 Sexually transmitted infection consultations, 2018–2022



Source: Institute for Government analysis of UKHSA, 'Sexually transmitted infections (STIs): annual data tables' ('Table 4: all STI diagnosis and service number in England and regions by gender and sexual orientation'), 2018 to 2022, supported by CIPFA.

Substance and alcohol misuse treatment: increasing contact with services hasn't translated into substantially more successful treatment

While spending on drug misuse treatment for adults increased by 2.0% to £396.9m in 2021/22, it remains 2% below 2019/20 levels and down 47% against 2013/14. By contrast, spending on alcohol misuse treatment only marginally increased to £195.0m in 2021/22, though this is 3% lower than 2019/20 levels and down 23% on 2013/14 levels. Preventative spending has improved more markedly between 2020/21 and 2021/22, by 7.0% for alcohol misuse in adults and 14.7% for drug misuse in adults, standing 2.0% and 11% higher in respective terms than 2019/20 levels.* Overall spending on drugs and alcohol treatment is likely to increase in 2022/23 and 2023/24 due to £154.3m of time-limited grants.⁵⁹

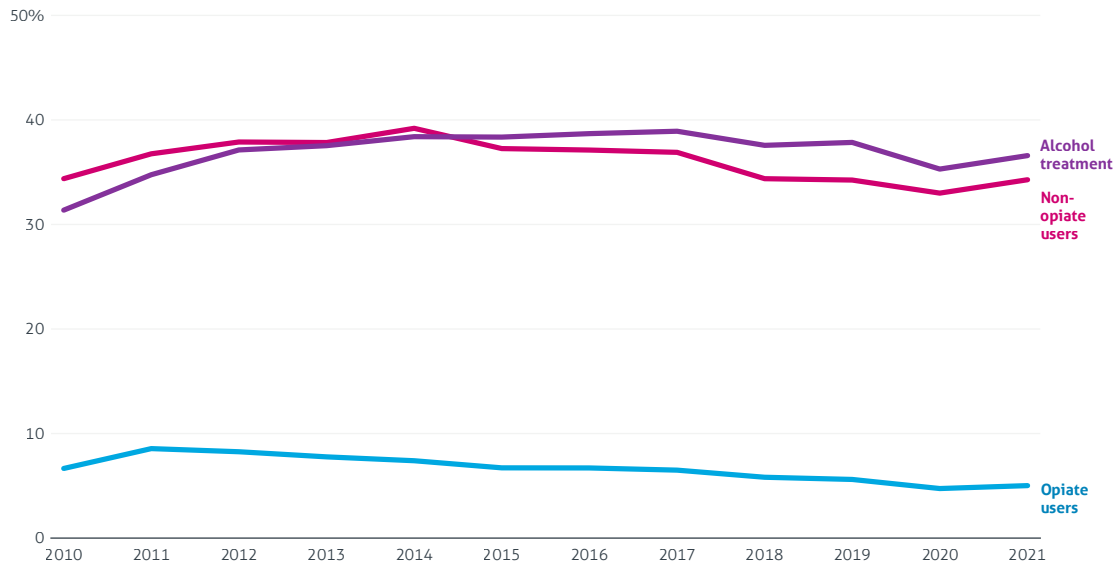
Between 2019/20 and 2021/22, the number of adults in contact with drug and alcohol services rose from 270,705 to 289,215, a 6.8% increase.⁶⁰ Despite this, the number of adults entering treatment in 2022 (133,704) was similar to the previous two years (130,490 and 132,124).⁶¹ The two biggest categories of need among those in treatment came from opiate treatment (49%) and alcohol treatment (29%),⁶² with the number accessing the latter up by 10% in 2021/22. Despite reaching 84,697 people in treatment, this is still substantially below the peak of 91,651 in 2013/14.⁶³

While there have been small improvements in the rate of successful completion of drug and alcohol treatments between 2020 and 2021, still only a minority of those who enter treatment complete it and do not return to treatment services in the following six months. In 2021, only 5.0% of people who attended opiate drug treatment programmes completed them successfully and did not return within six

* Disaggregated spending lines for preventative expenditure is not available for 2013/14.

months; the figure for non-opiate drug treatment programmes was 34.3%, and 36.6% for alcohol treatment programmes. In all cases, this is below the success rates achieved in the previous decade.

Figure 5.12 **Successful drug or alcohol treatment without relapse within six months, 2010–2021**

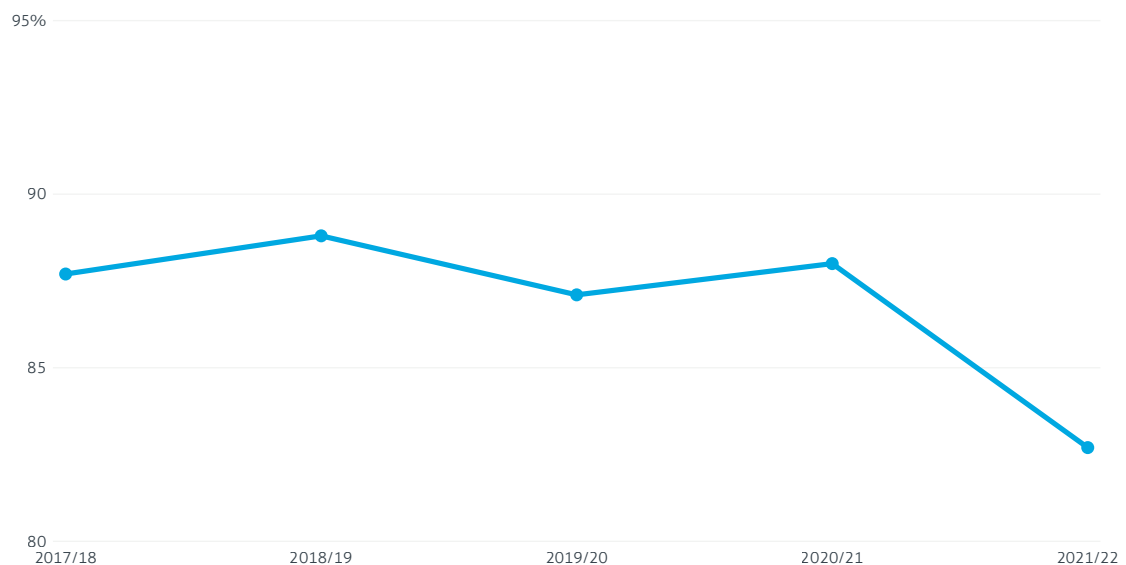


Source: Institute for Government analysis of OHID, *Public Health Outcomes Framework* data, retrieved 30 May 2023, supported by CIPFA.

A 17-year analysis by the Office for Health and Improvement Disparities (OHID) suggests that 14% of people starting to access treatment in England between 2005 and 2006 were still receiving treatment in March 2022.⁶⁴ Separate analysis by OHID shows that 42% of people in treatment in England at the end of March 2022 had accessed drug and alcohol treatment services four or more times before.⁶⁵

Children’s early years health programmes – proportionately fewer children are being seen by health visitors

Figure 5.13 **New birth visits completed within 14 days in England, 2017/18–2021/22**



Source: Institute for Government analysis of OHID, *Public Health Outcomes Framework* data, retrieved 30 May 2023, supported by CIPFA.

The proportion of babies visited within 14 days of being born fell markedly in 2021/22, from 88.0% to 82.7%. Analysis from the Institute of Health Visiting suggests that only 76% of new birth visits, 54% of 6–7 week postnatal contacts and 4% of 3–4 months check-ups are carried out by a qualified health visitor.⁶⁶ Indeed, England is an outlier in this respect, underperforming against other nations in the UK in terms of the percentage of check-ups undertaken by a qualified health visitor.⁶⁷

One factor that may have contributed to this is the 7.1% fall in the number of NHS-employed health visitors,* from 6,595 to 6,124 between 2020/21 and 2021/22.⁶⁸ This continues a longer-term trend, with the size of this workforce falling by around 40% across NHS and non-NHS providers.⁶⁹

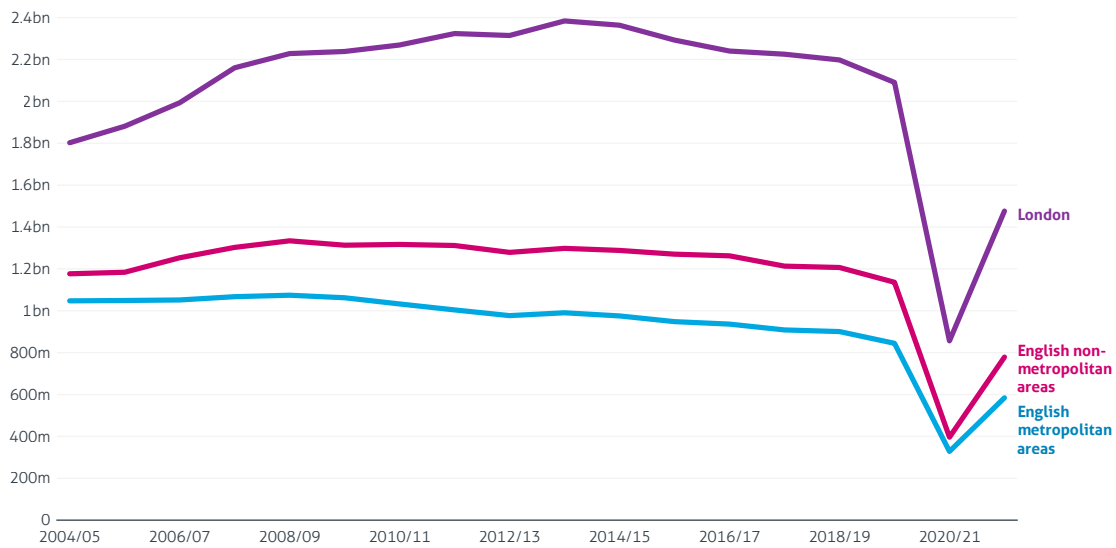
Workforce shortages have contributed to under provision of health reviews – a survey of health visiting practitioners in autumn 2022 showed that only 13% of health visitors in England are able to deliver antenatal contact to all families, only 54% are able to deliver the 6–8 week postnatal reviews to all families and only 15% are able to deliver the 9–12 month review to all families.⁷⁰ The Institute of Health Visiting estimates that as of November 2022, one in five children were missing out on vital health and development reviews.⁷¹ Analysis of the Healthy Child Programme in 2022 suggests that children from the most deprived backgrounds are marginally less likely to have a 2 to 2½ year health review than those from the least deprived backgrounds and, for local authorities where data was available, children in care were much less likely than others to have a health check recorded.⁷²

Demand for bus services has fallen, requiring greater government subsidy

Use of buses fell during the pandemic and has yet to return to pre-pandemic levels. In English metropolitan areas, 0.6 billion passenger journeys were made in 2021/22, up from 0.3 billion in 2020/21 yet still 30.8% below the 0.8 billion passenger journeys in 2019/20. Similarly, there were 0.8 billion passenger journeys travelled in English non-metropolitan areas in 2021/22, double the 0.4 billion in 2020/21 yet still 31.5% below the 1.1 billion passenger journeys in 2019/20.⁷³

* Health visitors are registered nurses or midwives that have received additional training in community public health nursing. The majority of public health nurses are employed by the NHS. The responsibility for commissioning health services, however, lies with local authorities. Delivery models vary across local authorities, with some health visiting services integrated into working with other teams. For examples of this see <https://www.local.gov.uk/sites/default/files/documents/improving-outcomes-childr-bf1.pdf>

Figure 5.14 Local bus journey travelled in England, 2009/10–2021/22



Source: Institute for Government analysis of DfT, 'Local bus passenger statistics' ('BUS01' table), March 2023, supported by CIPFA.

The drop in the number of bus journeys has been bigger in some groups than others. For example, elderly and disabled passenger numbers are down 38.2% in English metropolitan areas and down 42.7% in non-metropolitan areas in 2021/22.⁷⁴

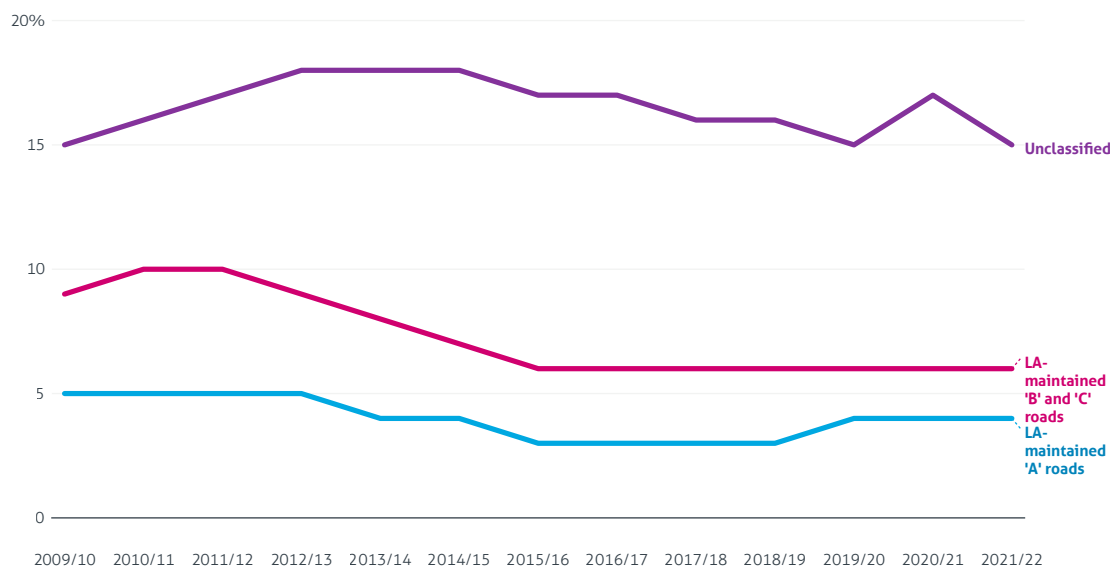
The fall in passenger numbers against pre-pandemic levels has challenged the commercial model of bus operators.⁷⁵ Prior to the pandemic, local authorities were already subsidising bus operators to provide services that would not be commercially viable without public support and to reimburse concessionary fares.^{*76} Yet even before the pandemic, analysis undertaken by the North East Combined Authority suggests grants failed to keep up with costs,⁷⁷ leading to services being left at risk of closure.⁷⁸

In July 2021, the government launched the temporary Bus Recovery Grant – a £226.5m fund to subsidise low bus fares and support bus operators.⁷⁹ This was supposed to be in place until March 2022.⁸⁰ Yet sustained pressure on bus operators, including higher fuel prices, pressures on staff recruitment linked to national driver shortages and DVLA licensing delays,⁸¹ has led to the scheme being extended repeatedly. Indeed, a House of Lords committee raised concerns in early 2023 that reducing this emergency support could lead to a reduction in services of up to 20%.⁸² In February 2023, the government provided a further £155m to extend the Bus Recovery Grant and the £2 bus fare cap until 30 June 2023,⁸³ with this later being extended until October 2023.⁸⁴ In May 2023, the government made a further £200m available to extend the £2 bus cap to 30 November 2023 and run a £2.50 bus cap to November 2024. The government also released £160m to local authorities to assist with the delivery of the government's national bus strategy between July 2023 and March 2025.

* Additionally, the Bus Services Operators Grant is paid by the Department for Transport directly to bus operators. For further details see <https://researchbriefings.files.parliament.uk/documents/CBP-8734/CBP-8734.pdf>, p. 20.

The performance of road maintenance services has remained steady

Figure 5.15 Roads in need of maintenance, 2009/10–2021/22

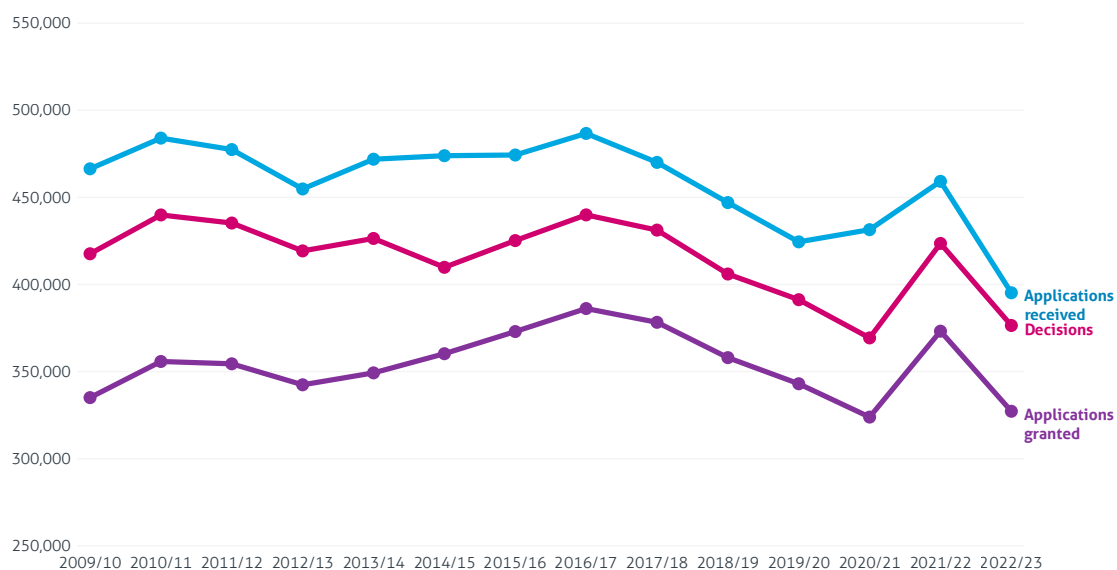


Source: Institute for Government analysis of DfT, 'Local authority managed classified/unclassified roads where maintenance should be considered' ('RDC0120' and 'RDC0130' tables), 2021/22, supported by CIPFA.

Following a 1.3% real-terms decline in spending between 2020/21 and 2021/22, there has been little change in the performance of road maintenance services. The proportion of local authority-maintained A, B and C roads that require maintenance has remained flat over the last year, continuing a longer-term trend since the mid-2010s. The number of unclassified roads in need of maintenance fell from 17% to 15%, but this only takes it back to where it was in 2019/20. Official data for 2022/23 has yet to be released, but estimates from the Asphalt and Industry Association (AIA) suggest a small deterioration in the quality of unclassified roads in the last year, with 16% of roads classified as red and 29% of roads classified as amber, up from 15% and 27% respectively in 2021/22.⁸⁵ The AIA estimates that the combined maintenance backlog across the network is now £14.02bn and would take 11 years to fully repair with adequate funding and resources.⁸⁶

A sharp fall in planning applications eased some pressures on planning departments, but many still face large backlogs

Figure 5.16 Planning applications received by local authorities, decisions made and applications granted, 2009/10–2022/23



Source: Institute for Government analysis of DLUHC, 'District planning authorities – planning applications received, decided, granted, performance agreements and speed of decisions, England' ('Table P120'), 2022/23, supported by CIPFA.

Spending on planning services increased 1.8% in real terms in 2021/22 to £1.2bn. This is 4.4% higher than in 2019/20, but remains 16.3% lower than in 2009/10.

There was a sharp rise in planning applications in 2021/22 (possibly attributable to a pandemic-era spike in home improvements), but the number of planning applications submitted has now returned to pre-pandemic trends, with 395,227 applications submitted in 2022/23, a 13.9% decline from 459,177 cases in 2021/22. The recent reduction may also reflect depressed demand, as higher prices reduce the viability of new projects.

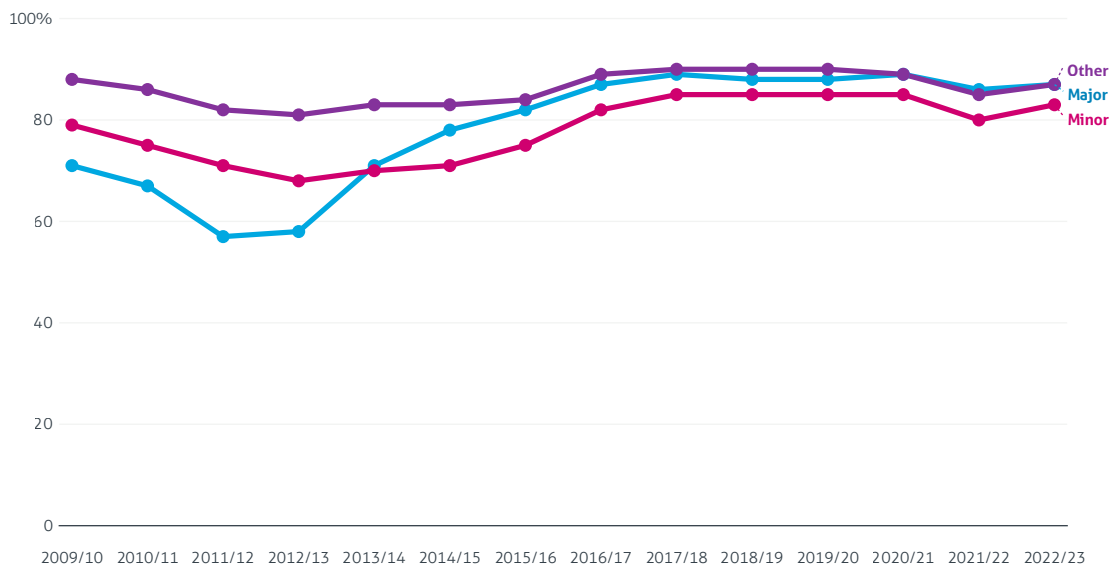
The reduction in demand has helped authorities to limit the expansion of the backlog of applications. In 2022/23, 87% of major planning applications, 83% of minor applications and 87% of other applications* were decided within time limits. This broadly returns performance to the pre-pandemic trend.

However, a significant minority of cases are still not decided within time limits, and earlier this year nine underperforming councils were instructed by DLUHC to improve their performance or face their cases being transferred to the planning inspectorate.⁸⁷ Further, 22% of architects' practices surveyed in April 2023 had needed to abandon projects in the past three months due to delays in processing of planning applications;⁸⁸ this was a threefold increase on the rate in 2021.⁸⁹

* Other applications include: householder developments, listed building consents, and other planning related decisions. For full details see <https://scams.moderngov.co.uk/documents/s42075/Adoption%20of%20Statement%20of%20Community%20Involvement%20-%20Appendix%201d%20-%20Types%20of%20planning%20applications%202601.pdf>

Industry commentators attribute this to local authorities struggling to recruit new staff following a mass exodus after the pandemic.⁹⁰ Only 1 in 10 council planning departments have their full staff complement and more than half of councils were at no more than 90% capacity between 1 January and 31 December 2022.⁹¹

Figure 5.17 **Planning applications decided within agreed time limit, 2009/10–2022/23**



Source: Institute for Government analysis of DLUHC, 'District planning authorities – planning applications received, decided, granted, performance agreements and speed of decisions, England' ('Table P120'), 2022/23, supported by CIPFA. Notes: Major decisions have a statutory time limit of 13 weeks and both minor and other decisions have a statutory time limit of eight weeks.

Local authorities face widespread recruitment and retention problems

Local government faces a long-term workforce capacity problem.⁹² While demands on councils have increased, the number of local authority staff was cut over the past decade: between Q4 2012 and Q1 2023 both headcount and FTE fell by 23.8%.⁹³

Local authorities now also face recruitment and retention challenges. In a survey conducted by the LGA, 94% of councils reported experiencing recruitment and retention difficulties, with 58% struggling to recruit planning officers and 53% having problems finding legal professionals.⁹⁴ Local authorities are struggling to compete with private sector pay and are losing staff because of it.⁹⁵ As one of the lowest-paying public sector employers, local government also faces competition from other public sector bodies like the NHS.⁹⁶

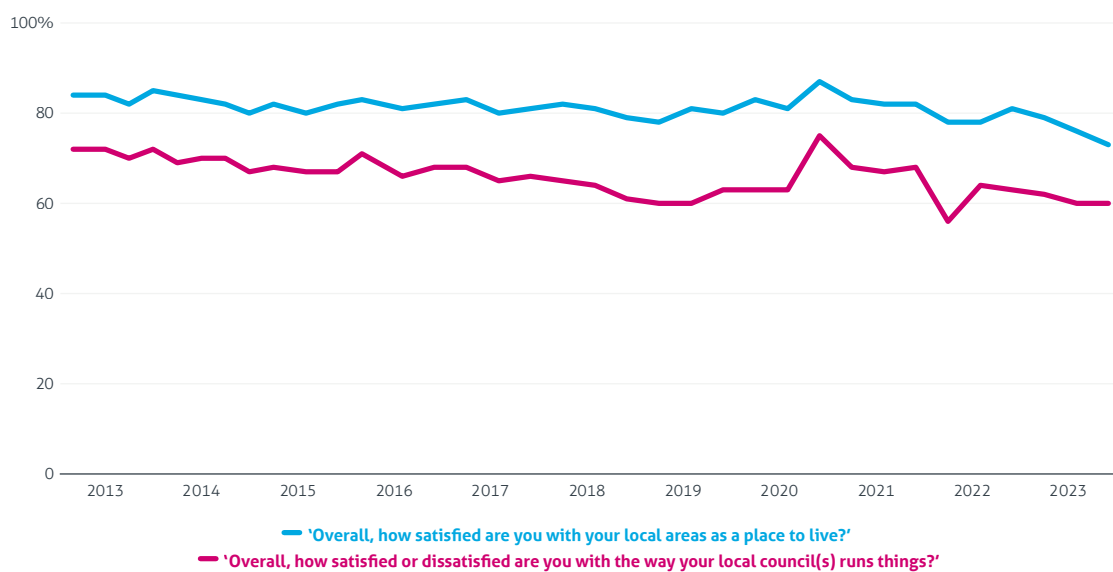
Local government may also face additional staffing challenges due to strikes. In February 2023, the LGA, acting for the National Employers' Council, offered staff a £1,925 pay rise effective from 1 April 2023 – equivalent to a 9.42% pay rise for those on the lowest salary band and 3.88% for those on the highest pay spines. The total increase to the national pay bill was estimated at £1.093bn.⁹⁷ This was rejected by 75% of Unite local authority staff (including refuse collection workers, housing workers and care staff),⁹⁸ 64% of GMB local authority members (including carers, school staff, social workers and refuse collection workers)⁹⁹ and council chief executives – who were offered a 3.5% uplift.¹⁰⁰ Only council service directors have

accepted the deal. While Unison (which represents some council employees) has decided against calling strike action, Unite staff at 23 local authorities are planning to strike in the autumn and ballots are under way at GMB to decide whether staff will undertake industrial action later in the year.¹⁰¹

While the current offer has been rejected by the majority of unions, it is nonetheless already higher than some councils anticipated for 2023/24.¹⁰² Councils may struggle to finance a higher settlement with no additional resources.¹⁰³

Satisfaction with councils is falling, but not evenly across areas or services

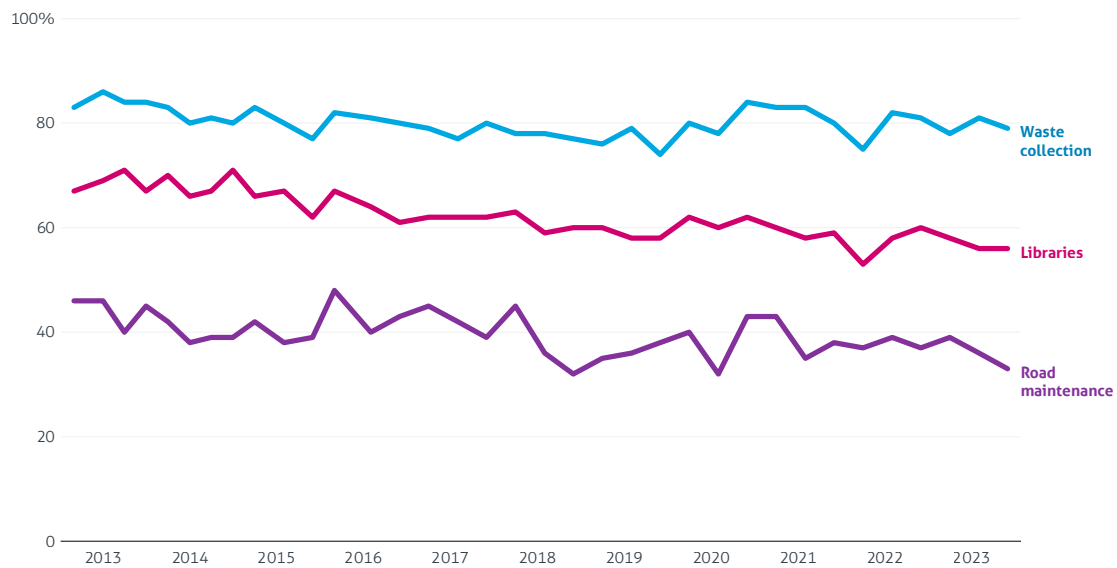
Figure 5.18 **Public satisfaction with local area and local council, September 2012 to June 2023**



Source: Institute for Government analysis of Local Government Association, 'Polling on resident satisfaction with councils: Round 35 – June 2023' ('Figure 1' and 'Figure 2'), supported by CIPFA. Notes: Polling was not carried out until 2012.

People's satisfaction with their local area reached its lowest level in over a decade in June 2023, though a large majority of residents, 73%, were still either very or fairly satisfied with their local area. Satisfaction with local councils has been in decline since February 2022, with 60% of residents now satisfied with their local council – on par with pre-pandemic series lows from October 2018 and February 2019. Overall, there has been a faster decline in satisfaction with local councils, which declined by 12 percentage points between September 2012 and June 2023 compared to an 11 percentage point decline in satisfaction with local area – though in both cases satisfaction recorded series highs at the onset of the pandemic.

Figure 5.19 **Public satisfaction with selected neighbourhood services, September 2012 to June 2023**



Source: Institute for Government analysis of Local Government Association, 'Polling on resident satisfaction with councils: Round 35 – June 2023' ('Figure 5'), supported by CIPFA. Notes: Polling was not carried out until 2012.

The trends for individual services differ – though data is not available for all services covered in this chapter. Satisfaction with both waste collection and libraries has declined slightly in the last year (to 79% and 36% respectively). While satisfaction with waste collection has remained broadly flat over the past decade, satisfaction with libraries has declined by 4 percentage points since June 2022. By contrast, satisfaction with road maintenance declined at a faster rate in the past year to 33%, in line with series low observations of 32% scored in February 2020 and June 2018.¹⁰⁴

6. Schools



Schools: key figures

- **7.8 million** – the number of pupils in state-funded primary and secondary schools in January 2023, up from 6.8 million in 2010.
- **437,000** – the number of full-time equivalent teachers in state-funded nurseries, primary and secondary schools, including school sixth-forms, in November 2022, up from 415,000 in 2010.
- **16.5%** – the fall in average, real-terms pay of a classroom teacher between 2010 and 2022.
- **£7,520** – the average per-pupil funding for primary and secondary pupils for the current school year, up from £6,911 in 2010/11.
- **6 percentage points** – the fall in the proportion of children at the expected standard in KS2 reading, writing and maths between 2019 and 2023.

Introduction

The start of the 2023–24 academic year was marked by a schools crisis. Some 104 schools and colleges were told by the Department for Education (DfE) at very short notice that they would not be able to reopen in part or in whole due to the risk posed by concrete used in their construction.

This followed disruption in the latter half of the previous school year, as members of the National Education Union went on strike for an accumulated eight days in a long-running dispute over pay. And while the government has provided additional money to fund the pay award that was eventually agreed, some schools will still find their finances are very tight.

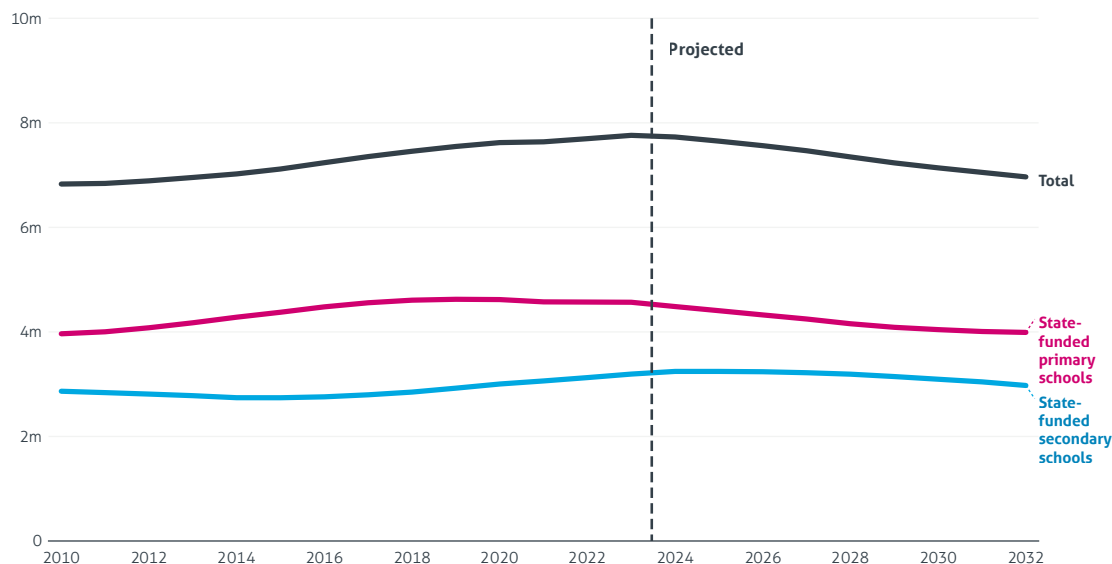
Meanwhile, the attainment of primary school pupils is considerably down on pre-pandemic levels and pupil absence rates have grown alarmingly.*

* This chapter focuses on mainstream, state-funded schools in England serving pupils aged 5–16. It covers both local authority maintained schools and academies but, unless otherwise stated, excludes special schools, alternative provision, early-years and post-16 education.

Pupil numbers have peaked

Demographic trends – namely a baby boom that ended in 2013 – mean pupil numbers have been declining for several years in primary schools and are forecast to peak in secondary schools in 2024.¹

Figure 6.1 Pupils, 2010–2032



Source: Institute for Government analysis of DfE, 'National pupil projections: Reporting year 2023', supported by CIPFA. Notes: Figures are as at January of the given year. Primary pupil numbers are higher than secondary pupil numbers as primary school covers more years of compulsory education. Primary pupil numbers also include pupils in nurseries at state primary schools.

The changes are not uniform across the country: primary pupil numbers have decreased by 5.1% in London since 2019, when numbers peaked nationally, while other areas have seen either more modest decreases or small increases.² Think tank and media reports have attributed this to a growing number of young people being unable to afford starting a family in the capital.^{3,4}

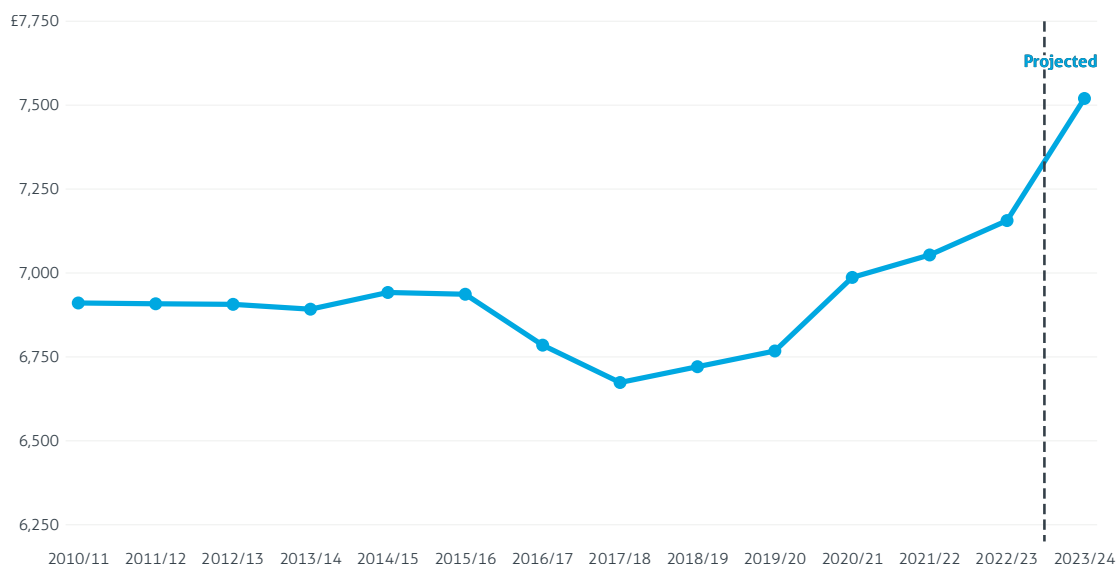
Alongside demographic changes there appears to have been a growth in home education since the start of the pandemic. Department for Education figures (published for the first time) estimated there were 116,300 children in elective home education at any point during the 2021–22* academic year.⁵ An estimate from the Association of Directors of Children's Services put the number of home-schooled children at around 79,000 in 2018–19.⁶

* This chapter refers to both academic school years and financial years. We refer to school years as 20XX–YY, and financial years as 20XX/YY.

Per-pupil funding has increased from recent lows

Core schools funding increased from £46.7bn in 2010/11 to £54.9bn in 2022/23 (both in 2023/24 terms), equating to a real-terms increase of 17.5%. Most school revenue funding is provided on a per-pupil basis, however, so some of this increase purely reflects the fact that overall pupil numbers are higher now than in 2010. Per-pupil funding fell in real terms between 2014/15 and 2017/18 – but by 2022/23 stood at £7,156 per pupil, the highest level to date, and 3.5% above 2010/11 levels.^{*,**,7}

Figure 6.2 Per-pupil funding, 2010/11–2023/24 (2023/24 prices)



Source: Institute for Government analysis of DfE, 'School funding statistics: Financial year 2022–23' (2010/11–2023/24) and figures provided directly by DfE (additional teacher pay grant, 2023/24), supported by CIPFA. Notes: Comparable figures are only available from 2010/11. Figures cover both mainstream and non-mainstream schools, and cover major revenue funding streams but exclude some smaller elements of revenue funding and specific Covid-19 funding. Figures for 2023/24 include extra funding to pay for the September 2023 teacher pay award. See Methodology for details of how figures have been put into 2023/24 terms.

While per-pupil funding has increased on average, the experience of individual schools varies. The government brought in a national funding formula in 2018/19 to address discrepancies in the funding that similar schools in different parts of the country received – but subsequent changes have been brought in to more generally 'level up', or equalise, funding nationally.^{8,9}

Schools serving more deprived communities still get more funding per pupil than those in less deprived ones. But analysis by the National Audit Office (NAO) found that between 2017/18 and 2020/21 most London boroughs saw real-terms decreases in per-pupil funding, as did other areas with relatively high levels of deprivation such

* Figures have been put into 2023/24 terms using a smoothed version of the Office for Budget Responsibility's GDP deflator. See Methodology for further details. These figures cover both mainstream and non-mainstream schools, and cover major revenue funding streams but exclude some smaller elements of revenue funding and specific Covid-19 funding.

** Including school sixth-forms, where there were greater funding cuts in the years after 2010 than in 5–16 education, the Institute for Fiscal Studies has calculated that spending per pupil will only return to 2010/11 levels in 2023/24 – and if a schools-specific measure of inflation is used, funding will not in fact have returned to that level by the end of the current spending review period, 2024/25. See Sibieta L, 'What is happening to school funding and costs in England?', Institute for Fiscal Studies, 5 October 2023, retrieved 10 October 2023, <https://ifs.org.uk/articles/what-happening-school-funding-and-costs-england>

as Nottingham and Birmingham. Conversely, local authorities with lower levels of deprivation in the South West, the East Midlands and the South East received real-terms increases.¹⁰

Analysis of changes up to 2021/22 by the Education Policy Institute, meanwhile, concluded that “the link between funding and pupil need is being weakened”, on average benefiting schools in more affluent areas.¹¹

Far more pupils have special education needs and disabilities, increasing spending on this

As well as growth in overall pupil numbers since 2010, there has been a huge increase in the number of pupils with education, health and care plans (EHCPs). These are issued where a child requires a higher level of special educational needs and disabilities (SEND) support, and set out in detail the support required. The number of EHCPs has increased from 232,000 (2.8% of all pupils) in 2014 to 389,000 (4.3%) in 2023.* Around half of pupils with EHCPs are in state-funded mainstream primary and secondary schools. (Most other pupils with EHCPs attend state-funded special schools, but a sizeable minority attend independent special schools.)¹²

Growth in the number of pupils requiring this higher level of support has been at least partly driven by what the government has described as a vicious cycle: a lack of inclusivity in mainstream schools coupled with late intervention leading to escalating needs, prompting families or schools to seek EHCPs, which in turn means more resources are diverted from mainstream provision, prompting more late intervention.¹³ Other factors include more common diagnoses of developmental disabilities such as autism.¹⁴

For pupils with SEND in mainstream schools, the first £6,000 of spending on additional support must be funded from schools’ general funding allocations, but separate ‘high needs’ funding exists to cover support above this level. High needs funding from the DfE pays for places in special schools and spending on alternative provision – and funds learning support for young people with SEND outside of school ages (up to age 25).

High needs funding is expected to total £10.1bn in 2023/24, an increase of 35.9% in real terms since 2019/20. This is much greater than the rise in core schools funding, which over the same period has increased by 11.4% in real terms.**¹⁵ Despite the enormous increase in high needs funding, in 2021/22, three quarters of local authorities were in deficit on the part of their education budgets reserved for schools spending due to the cost of meeting their statutory SEND duties. As of March 2022, the combined deficit totalled £1.4bn, up from £1.0bn a year earlier (discussed further in the ‘Cross-service analysis’ chapter).¹⁶

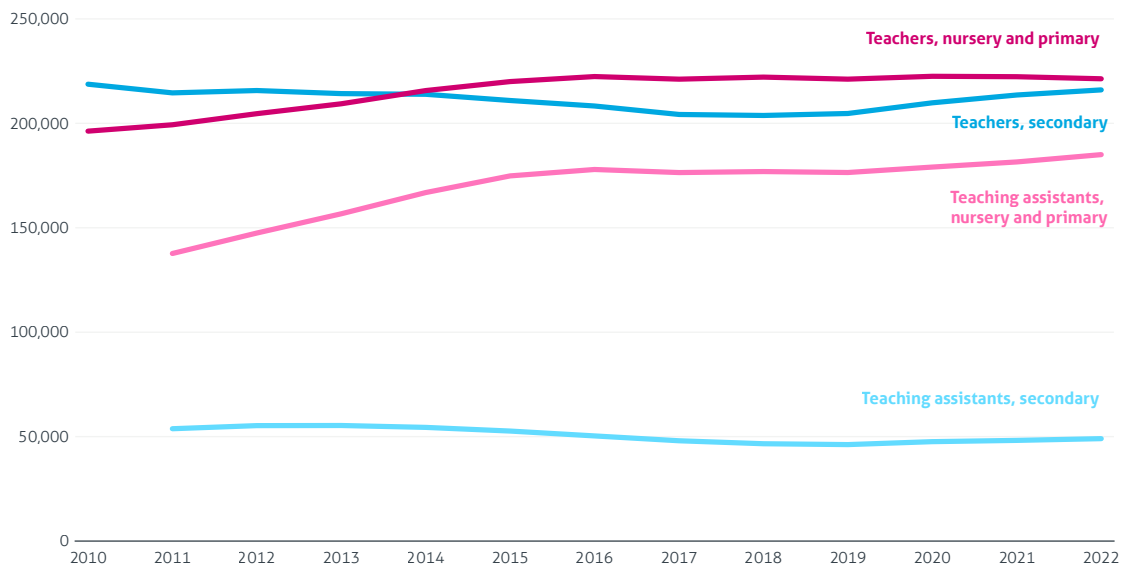
* The SEND system was reformed in 2014. The SEND system now covers young people up to the age of 25, but these figures relate specifically to school pupils. Figures in the first years after the reforms include SEN statements, which were replaced by EHCPs.

** Some of this includes high need funding. However, it is not possible to determine how much as no breakdown is available.

There are record numbers of teachers but the government is missing initial teacher training targets by a huge margin

Both teacher and teaching assistant numbers reached a record high in 2022.^{17,18} In the case of teacher numbers, this was driven by growing numbers of teachers in secondary schools, masking a slight decline in primary teacher numbers. (In this section, figures for primary schools includes those working at nursery level and figures for secondary schools includes those working in school sixth-forms.)

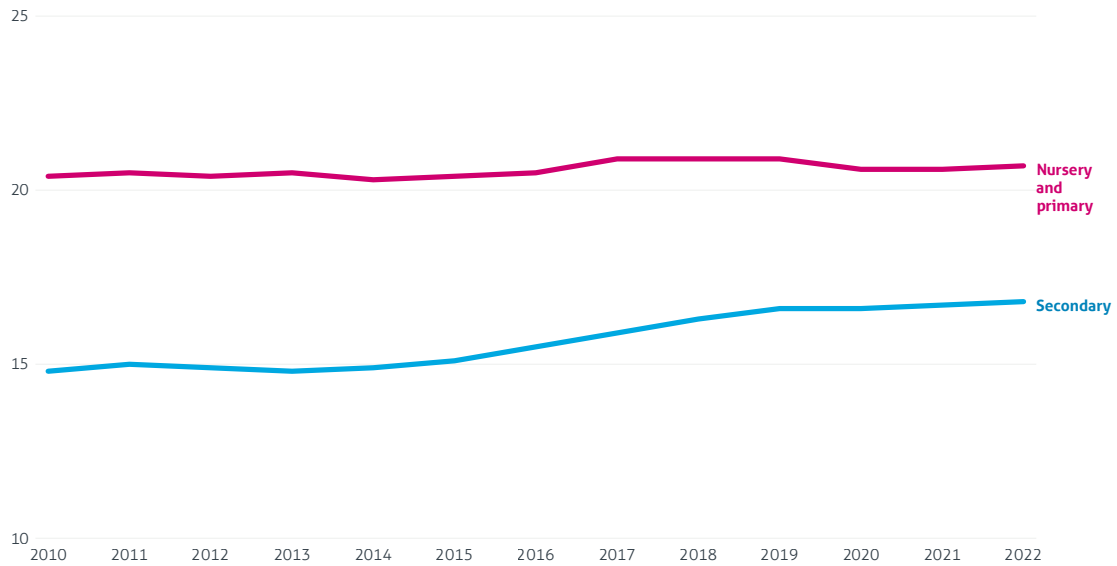
Figure 6.3 Teachers and teaching assistants (FTE), 2010–2022



Source: Institute for Government analysis of DfE, 'School workforce in England: Reporting Year 2022' ('The size of the school workforce' table), supported by CIPFA. Notes: Teaching assistant numbers are not available for 2010. Figures are as at November of the given year. Secondary includes school sixth-forms.

With pupil numbers peaking, these numbers mean pupil–teacher ratios have been broadly stable in primary schools since at least 2010. The ratios had deteriorated considerably for secondary schools between 2013 and 2019, but have been broadly stable since then.¹⁹

Figure 6.4 Pupils per teacher, 2010–2022

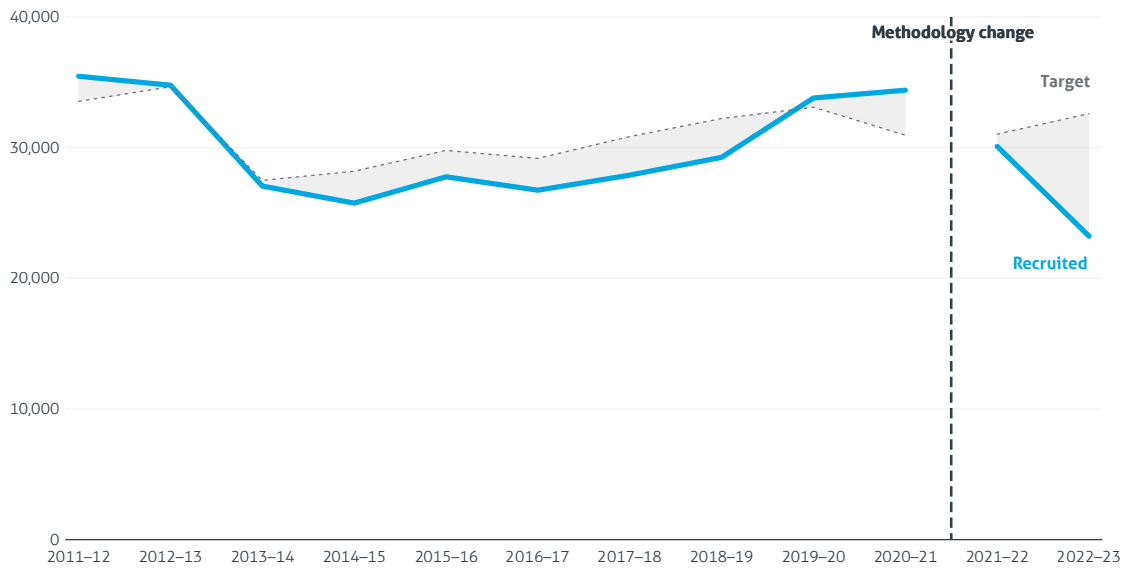


Source: Institute for Government analysis of DfE, 'School workforce in England: Reporting year 2022' ('Pupil to teacher ratios' table), supported by CIPFA. Notes: Ratios are based on teacher numbers in November of the stated year and pupil numbers in the following January. Secondary includes school sixth-forms. Figures include both qualified and unqualified teachers.

Recruitment to initial teacher training courses is at crisis levels, however. The government sets annual targets covering postgraduate training, which accounts for the bulk of teacher training. These targets are intended to make sure that the schools system has sufficient numbers of teachers in future, based on trends in pupil numbers and assumptions about teacher leaver rates. The numbers entering postgraduate training have dropped starkly since the pandemic, coming in at only 23,000 in 2022–23, around 30% below target. And the picture is particularly bad in some secondary school subjects – a target for physics, the worst performer, was missed by 83%.²⁰

In recognition of the recruitment crisis, in October 2023 the government doubled the size of grants for new teachers of some shortage subjects working in certain deprived parts of the country, to £6,000 annually for five years.²¹

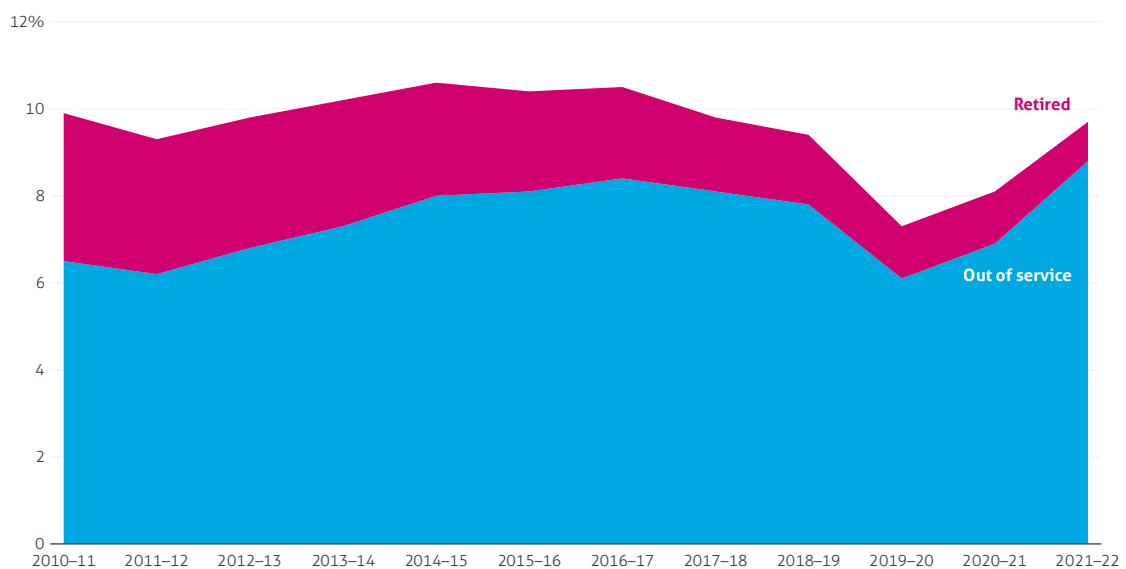
Figure 6.5 Postgraduate initial teacher training recruitment, 2011–12 to 2022–23



Source: Institute for Government analysis of DfE, 'Initial teacher training census' ('ITT new entrants and targets by subject time series' table), 2015/16–2022/23, supported by CIPFA. Notes: Comparable figures are not available for 2009–10 and 2010–11. Since 2021–22 DfE has taken under-recruitment in the preceding two years into account in setting subject targets.

The share of teachers leaving the state-funded school system fell with the onset of the pandemic but has subsequently returned to pre-pandemic levels – and the out-of-service leaver rate, covering those who quit for other work or education (as opposed to retiring or dying) reached its highest level since at least 2010–11 in 2021–22.²² Institute for Government research on public sector retention published in October 2023 identified disgruntlement over workloads and a lack of flexible working as well as unhappiness over pay as factors behind increasing exit rates.²³

Figure 6.6 Teacher leaving rate by reason, 2010–11 to 2021–22

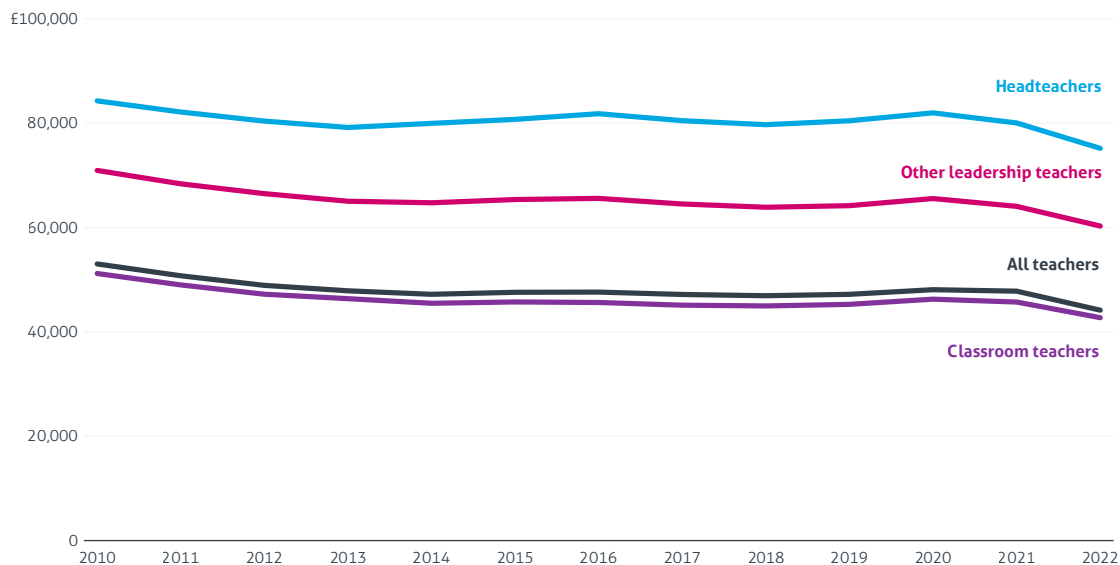


Source: Institute for Government analysis of DfE, 'School workforce in England: Reporting Year 2022' ('Qualified leavers from teaching' table), 15 June 2023, supported by CIPFA. Notes: Figures are only available from 2010–11 and include teachers in non-mainstream settings. Deaths in service translate to a rate of 0%. Periods do not align exactly with the academic year; e.g. 2021–22 covers November 2021 to November 2022.

Staff pay is schools' biggest cost and has increased by less than inflation

Staff costs account for around 80% of school spending.²⁴ In 2011–12 and 2012–13 there were pay freezes for those working in schools, in common with other areas of the public sector, with below-inflation pay awards between 2013–14 and 2017–18. This, coupled with high inflation since 2021, means median pay fell by 16.5% in real terms between 2010 and 2022 for classroom teachers, by 15.0% for those in leadership roles excluding headteachers, and by 10.8% for headteachers.^{25,26}

Figure 6.7 Median teacher pay by role, 2010–2022 (2023 prices)



Source: Institute for Government analysis of DfE, 'School workforce in England: Reporting Year 2022' and OBR, 'Economic and fiscal outlook March 2023 – supplementary economy tables' ('Table 1.7'), supported by CIPFA. Notes: Figures cover all teachers including those in non-mainstream schools, early-years and post-16. Figures are as at November of the given year. Figures for 2022 may not include the full effect of 2022–23 pay awards due to the late publication of school teachers' pay and conditions details for that year.

Disgruntlement with 2022–23 pay awards led to members of the National Education Union (NEU) going on strike for eight days between February and July 2023.²⁷ The strikes ended after the NEU and other teaching unions accepted a pay deal in July that gives teachers a 6.5% pay rise for 2023–24 – though one union, NASUWT, is continuing with action short of a strike over teacher working hours and workload.^{28,29}

Given the crisis in initial teacher training recruitment, the National Foundation for Educational Research has said that the 6.5% pay award is welcome.³⁰ It has, however, warned that pay will need to increase by more than average earnings in the economy as a whole in future years if there is to be a significant improvement in teacher recruitment and retention.³¹

Besides teacher salaries, pay deals covering many school support staff increased pay by up to 10.5% for the lowest paid staff in 2022/23,* while a proposed award for 2023/24 would raise pay by up to 9.4%. (In both years, pay offers are for a fixed amount of £1,925 – which translates into a large increase in percentage terms for generally low-paid support staff.)³²

* These pay awards cover financial years, unlike the pay awards covering teachers.

School financial health improved on average during the pandemic

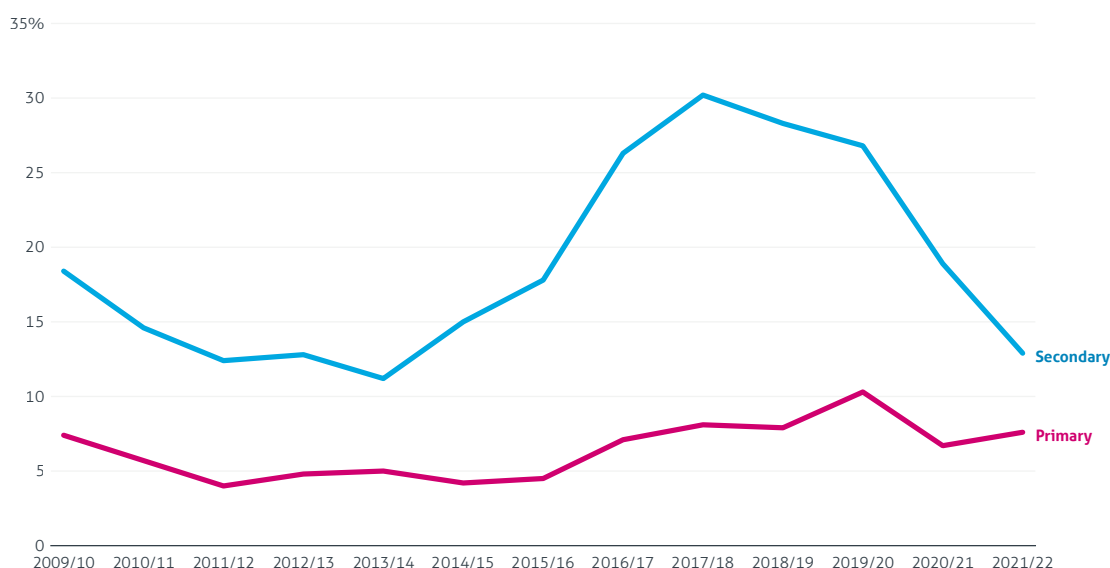
School income and expenditure were both affected by the pandemic. The Department for Education provided schools with some specific Covid-19 revenue funding, while schools' self-generated income – such as from letting out meeting spaces and sports halls – fell. Schools spent more on teaching and support staff, but expenditure on exam fees, development and training, and indirect employee expenses all decreased.³³

Overall, school income increased by more than expenditure for the typical school in 2020/21* – and DfE has concluded that this would have been true even without Covid-specific grant funding, because of increases in general revenue funding.³⁴

The share of schools and academy trusts with cumulative negative reserves** can be used as a proxy for the financial health of the system. For local authority maintained schools, where data is more available than for academies, the picture has been far more variable for secondary schools than for primary schools since 2009/10.

The percentage of maintained secondary schools with cumulative negative reserves increased from 11.2% in 2013/14 to a high of 30.2% in 2017/18, during which time per-pupil funding was stagnant or falling in real terms and secondary school pupil numbers were increasing. The share of schools in this position has fallen sharply since then, reaching 12.9% in 2021/22, due to per-pupil funding increasing in real terms, and income going up by more than expenditure on average during the pandemic. For local authority maintained primary schools, the proportion of schools in poor financial health has stuck within a smaller range, ending 2021/22 at a level similar to that seen in 2009/10.^{35,36,37}

Figure 6.8 Local authority maintained schools with negative financial reserves, 2009/10–2021/22



Source: Institute for Government analysis of DfE, 'LA and school expenditure' ('LA maintained schools, revenue reserves' table), 2010–2022, supported by CIPFA. Notes: Figures relate to revenue (day-to-day) spending.

* 2020–21 for academies, whose financial years are aligned to the academic year, unlike those of local authority maintained schools.

** Reserves show the cumulative financial position of schools. If schools record in-year deficits this can ultimately lead to them building up negative reserves – in this situation, local authority maintained schools are reliant on their local authority supplying additional funding. Academy trusts are reliant on support from the Education and Skills Funding Agency.

For academy trusts, including those covering non-mainstream schools, the proportion with cumulative negative reserves decreased from 4.1% to 2.6% between 2019–20 and 2020–21, the first full school year of the pandemic.^{38,39} More recent figures have not been published for academies.

Funding increases for 2023/24 exceed expected cost increases

Looking ahead, per-pupil funding is increasing from £7,156 in 2022/23 to £7,520 in 2023/24 (both in 2023/24 terms), equating to a 5.1% increase.^{40,41} This comes after the government increased schools funding at the 2022 autumn statement, and separately provided £432.5m of funding for 2023/24 towards the cost of the September 2023 teacher pay award. (The government will provide a further £742.5m to cover the cost of the pay award for 2024/25).⁴²

The Department for Education describes the 6.5% teacher pay award as “properly funded” – that is, nationally, increases in funding cover expected cost increases for schools, helped by energy bills coming in lower than expected, plus this additional funding from the department.⁴³ On its calculations, the funding provided in the 2022 autumn statement means schools could on average afford a 4% pay award, while the additional grant funding is sufficient for a 3% teacher pay award. Taking these figures together, the department says that the additional funding being made available in 2023/24 is more than is strictly needed to cover the 6.5% pay award.⁴⁴

This ignores the distributional effect, however – some schools will be more affected than others. The department does not model the effect on individual schools, though schools in London – which have received lower than average per-pupil funding increases in 2023/24⁴⁵ – and schools with high SEND rates employing more support staff are more likely to feel financial pressure than some of their peers.

The Department for Education has said that the additional funding for the pay award will come from its existing budget, but has said that core school and college budgets will not be cut.⁴⁶ In part, funding will come from an underspend on the National Tutoring Programme, which DfE has gained permission to retain rather than pass back to the Treasury.⁴⁷ Beyond 2023/24 and 2024/25, the ongoing cost of the teacher pay award is likely to require further money from the Treasury.

In the medium term, the government’s success in implementing its SEND and alternative provision improvement plan, published in March 2023, will also have a material effect on spending on both mainstream and special schools. This plan aims to improve experiences of the SEND system, standardise provision nationally and make mainstream education more inclusive.⁴⁸ The plan’s broad principles have support from the sector, and, if implemented successfully, could act as a brake on soaring high needs spending by reducing the use of independent provision.^{49,50,51}

Changes are likely to meet opposition from parents, however, who would face a restriction of school choice for their child. This, together with a lack of detail on the level around which provision will be standardised – in line with the best support available now, or at a lower level – make it hard to quantify the future impact.

* These figures relate strictly to mainstream primary and secondary schools. Figures of £482.5m and £827.5m reported elsewhere include £50m and £85m of post-16 funding for 2023/24 and 2024/25 respectively.

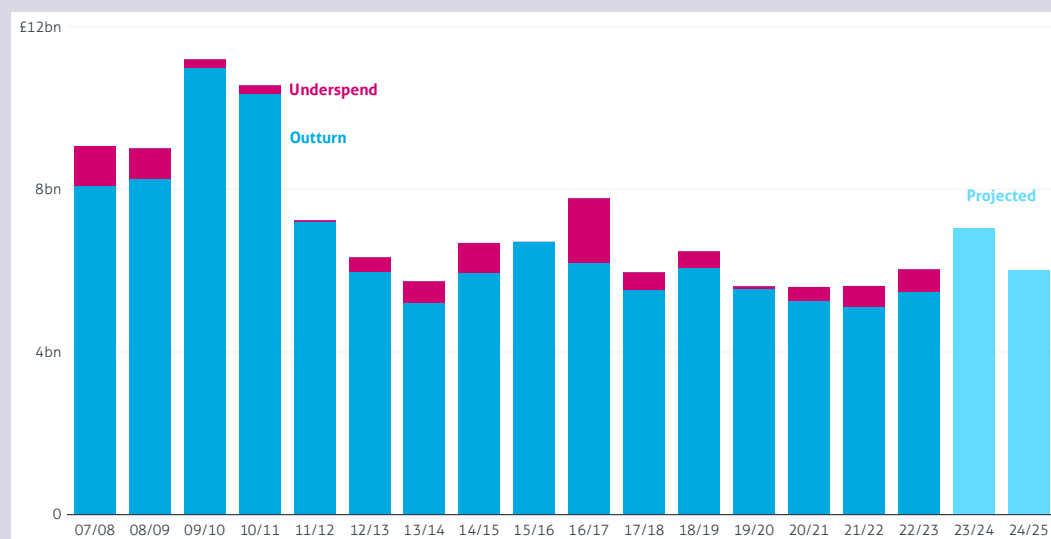
Box 6.1 The school estate

Just days before the start of the current academic year, 104 schools and colleges were ordered not to reopen in part or in whole by DfE due to the risk of collapse posed by concrete used in their construction.⁵² Further investigations took the total number of institutions with confirmed cases of reinforced autoclaved aerated concrete (RAAC) in their buildings to 214 by 16 October 2023, the latest date for which figures are available.⁵³

The department has considered the risk of a school building collapse to be 'very likely' since July 2021 and is prioritising affected schools in a rebuilding programme, though the head of the NAO has said that the risks posed by RAAC took too long to be addressed.^{54,55}

This comes after capital spending by DfE – the vast majority of which goes on schools – decreased markedly after the government cancelled the Building Schools for the Future programme in 2010.⁵⁶ Even before the latest problems with RAAC emerged, the NAO reported in June 2023 that "in recent years, funding for school buildings has not matched the amount DfE estimates it needs, contributing to the estate's deterioration".⁵⁷

Figure 6.9 Department for Education capital spending, actual and forecast, 2007/18–2024/25 (2023/24 prices)



Source: Institute for Government analysis of HMT, *Public Expenditure Statistical Analyses* ('Table 1.6/1.8/1.10' and 'Table 3.2/3.3/3.7'), 2019–2023, supported by CIPFA. Notes: Not all DfE capital spend relates to schools. Figures have been adjusted to account for machinery of government changes. In 2015/16 DfE had a capital overspend of £0.1bn.

The last survey of the school estate, carried out between 2017 and 2019 and published in May 2021, estimated the cost of returning all elements of the primary and secondary school estate to a good condition at £10.6bn.* There was considerable variation in the condition need by region, with schools in the East Midlands, for instance, requiring around twice as much investment per square metre as those in the South West.⁵⁸

* Including non-mainstream schools, early-years and post-16 provision the total was £11.4bn.

Planned DfE capital spending of £7.0bn for 2023/24 is higher in real terms than capital budgets have been at any point since 2016/17, though is 13.1% below the level seen in 2007/08, and even further below the unusually high amounts seen in 2009/10 and 2010/11.⁵⁹ With total pupil numbers peaking, capital spending on mainstream schools is shifting from adding new capacity to repairing and replacing existing buildings. New DfE capital spending also covers a big planned expansion in special school capacity and extra spending on colleges and children’s homes.⁶⁰

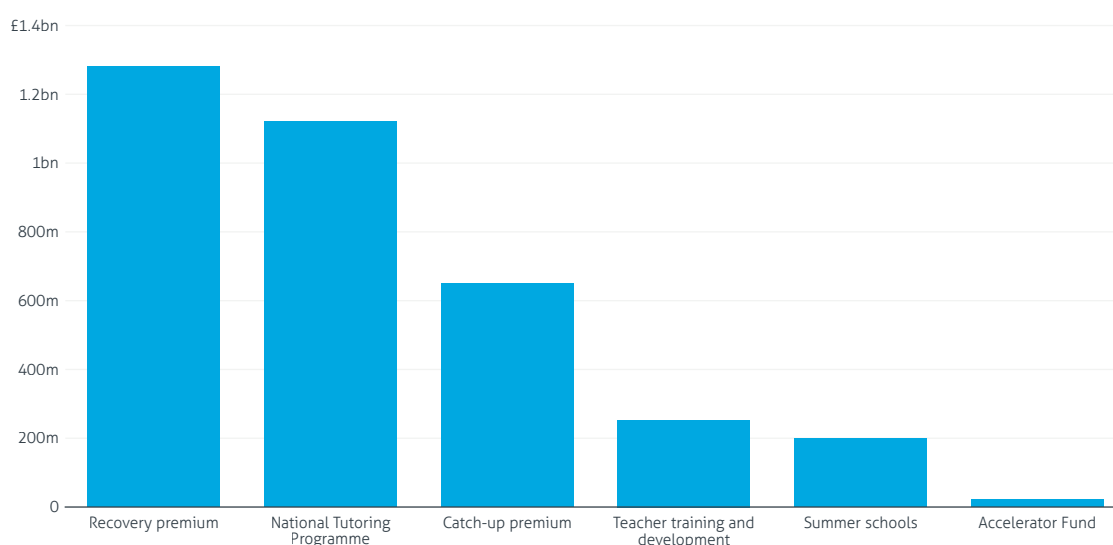
Catch-up programmes are not likely to reach as many pupils as intended

In-person teaching was severely disrupted over the course of two academic years as a result of Covid,⁶¹ while a sharp increase in absence rates since has further disrupted many pupils’ learning. More than one in six primary school pupils (17.2%) and more than one in four secondary school pupils (28.3%) are estimated to have been persistently absent in 2022–23 – defined as missing 10% or more of school sessions.⁶² This has been blamed on a number of factors, including attitudinal change following the pandemic.^{63,64,65}

The government has a £4.9bn package of education catch-up measures, announced in 2020 and 2021 and allocated between the 2020–21 and 2023–24 school years.⁶⁶ This is significantly less than the roughly £15bn that had been recommended by the government’s education recovery commissioner.⁶⁷ Most of the sum made available (£3.5bn) is allocated to schools, with the rest allocated to early-years and 16–19 education.⁶⁸

Two of the main components of this support – the ‘catch-up’ and the ‘recovery’ premiums – have provided schools with £1.9bn of funding for general use, with limited conditions attached.^{69,70} The other main component is the government’s £1.1bn National Tutoring Programme (NTP), launched in November 2020.⁷¹

Figure 6.10 **Education catch-up funding committed to schools, 2020–21 to 2023–24 (cash terms)**



Source: Adapted from NAO, *Education recovery in schools in England* ('Figure 1'), February 2023, supported by CIPFA. Notes: Catch-up premium and recovery premium are two types of funding supplied to schools with limited conditions attached. The Accelerator Fund is intended to scale up evidence-based literacy and numeracy interventions. Some Covid-19 support isn't included, e.g. funding for digital devices.

The NAO noted in February 2023 that catch-up interventions designed by the DfE were informed by evidence, but expressed concern that disadvantaged pupils* – ostensibly the main focus of recovery efforts – were still exhibiting higher levels of learning loss than other pupils.⁷²

Ofsted, the schools inspectorate, also carried out a review of the NTP based on visits to a sample of 63 schools during the scheme’s second year. This found that in more than half the schools, tutoring was strong, with tutoring in some of the other schools visited having strong features. However, in 10 of the schools tutoring was “haphazard and poorly planned”. Ofsted also noted that schools generally had not yet developed efficient means of assessing the impact of the tutoring.⁷³

An estimated 3.8 million tutoring courses under the NTP had been started between its launch in 2020 and May 2023.⁷⁴ The government is forecasting that only 1 million courses will be delivered in 2023–24, the final year of the scheme, versus an earlier expectation of twice that, however – leading it to drop an overall target of 6 million courses taken over the life of the programme.⁷⁵

NTP funding is a subsidy towards the cost of tutoring, with schools having to find the rest of the cost from their general funding and the level of subsidy reducing over time. Lower forecast demand, therefore, suggests that schools either cannot afford to fund the balance, or are not seeing sufficient value in the tutoring.

Primary school attainment has dropped markedly since the pandemic

The government cancelled key stage 2 (KS2) assessments, covering pupils at the end of primary school, in 2020 and 2021. KS2 assessments resumed in 2022, with the results showing a fall in the percentage of pupils meeting the expected standard in reading, writing and maths from 65% in 2019 to 59% in 2022, driven by steep falls in maths and writing attainment.⁷⁶

In 2023, some 59% of pupils again met the expected standard in reading, writing and maths – though with reading results falling and maths and writing results improving.⁷⁷ This leaves the government well behind on a target introduced in 2022: to get 90% of pupils at the expected standard in reading, writing and maths by 2030.⁷⁸ Since assessments resumed after the pandemic, the gap in attainment between disadvantaged pupils and their better-off peers has also widened to levels last seen in 2012.⁷⁹ Given pupils who completed KS2 assessments in 2023 may have benefited from up to two and a half years of tutoring under the NTP, the results raise further questions about the effectiveness of this programme.

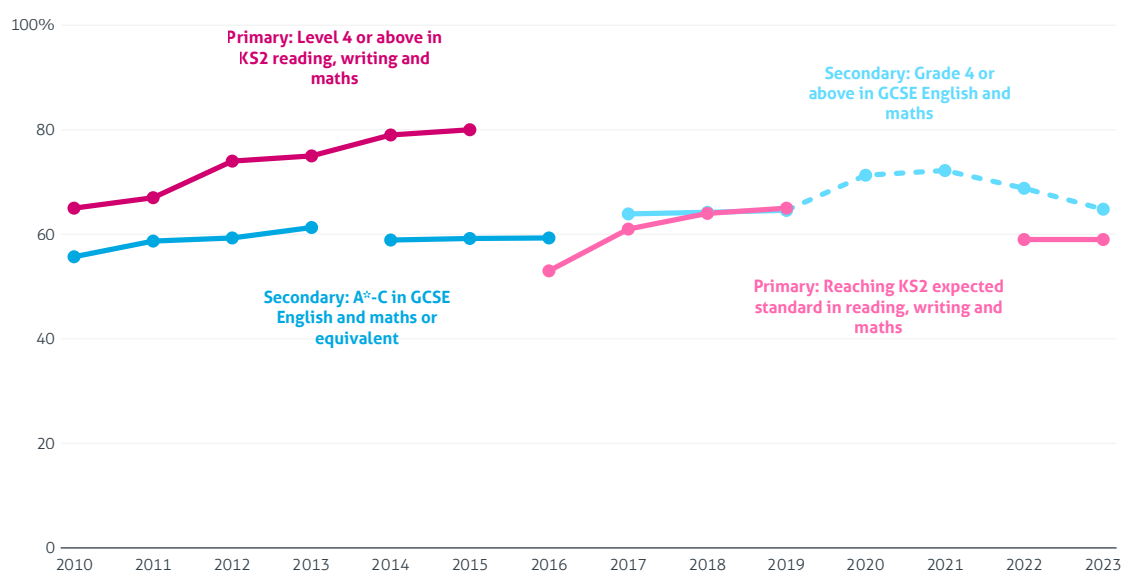
For secondary pupils, GCSE exams and other external assessments were also cancelled in 2020 and 2021 – with a major backlash in 2020 against plans to use an algorithm to set grades. GCSE grades were set instead by schools and regulators in 2020, and schools in 2021, following national guidelines, and were considerably higher than those in previous years.⁸⁰ GCSE exams also restarted in 2022, with results

* Defined as being eligible for free school meals in the previous six years.

set between 2019 and 2021 levels, while in 2023 grades were allowed to return to pre-pandemic levels, with some grading protections to ensure they were not below 2019 levels.^{81,82}

These factors mean GCSE results are of little value when trying to compare the overall performance of the 2022 and 2023 cohorts to that of earlier cohorts. Alternative evidence on the attainment of secondary school pupils – the National Reference Test, taken by a sample of 16-year-olds each year – did not, however, find statistically significant changes in overall attainment in English and maths between 2017 and 2023 at most of the attainment levels measured in the test.⁸³ But similarly to KS2, GCSE results for 2023 have seen the gap in attainment between disadvantaged pupils and their non-disadvantaged peers reach its widest point since 2011.⁸⁴

Figure 6.11 **Attainment at the end of primary and secondary school, 2010–2023**



Source: Institute for Government analysis of DfE, key stage 2 statistics, 2010–2023 and DfE, GCSE and equivalent results (national tables), 2010–2023, supported by CIPFA. Notes: All figures include those not in mainstream education. KS2 assessments did not take place in 2020 and 2021. GCSE results were awarded on the basis of centre-/teacher-assessment rather than external assessment in 2020 and 2021, while in 2022 they were set between pre-pandemic, 2019 levels and 2021 levels, and in 2023 they were allowed to return to pre-pandemic levels, with some grading protections in place. See Methodology for a description of earlier changes.

On the other main school accountability measure – inspection ratings – 90% of primary schools and 81% of secondary schools were rated as either being ‘good’ or ‘outstanding’ by Ofsted as at 31 July 2023.⁸⁵ This is higher than was the case before the pandemic, though with fewer outstanding ratings.⁸⁶ This follows the removal of an exemption from inspection for schools holding this rating in 2020, with most of these schools dropping to a good rating when inspected.⁸⁷

7. Police



Police: key figures

- **0.9%** – the real-terms increase in police spending in England and Wales in 2022/23.
- **8,655,504** – the number of victim-based crimes reported in 2022/23, a 15.2% decline on 2019/20.
- **8.9%** – the minimum increase in the number of charges/summonses in 2022/23, corresponding to a charge rate of 5.7%.*
- **20,947** – the increase in police officer headcount between October 2019 and March 2023.
- **51%** – the proportion of people who feel that their local police are doing a good or excellent job. That equates to a 5-percentage-point decline on 2019/20 and the lowest proportion since at least 2009/10.

The police service faces an array of challenges. Levels of public trust are at historically low levels – a consequence of a litany of scandals (and repeated failures to address these) and a general and widespread belief that the police cannot adequately deal with crime. While overall levels of reported crime have declined over the last 10 years, so too have charge rates. In the period, police resources have been stretched by the combination of increasing crime complexity and growing non-crime demands.

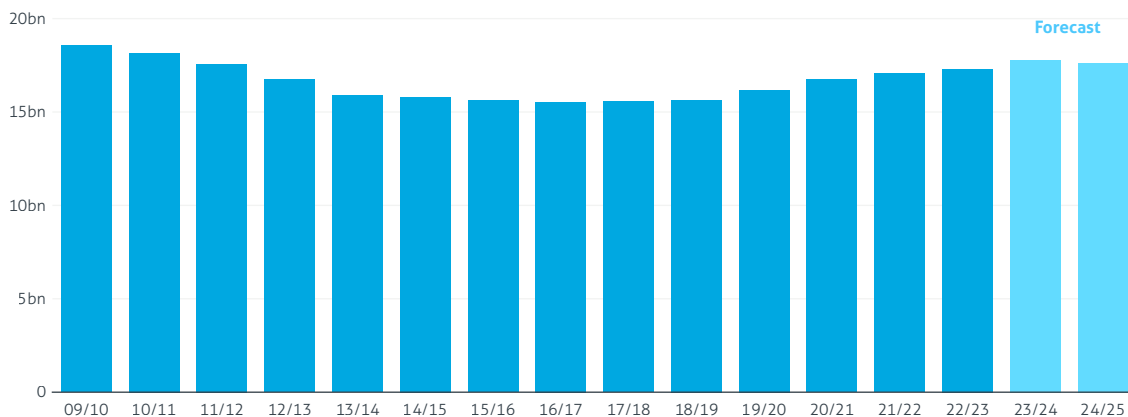
Police spending has increased significantly in recent years, largely to support the successful recruitment of an additional 20,000 police officers. The decline in the charge rate has been halted, and the absolute number of charges increased in 2022/23 for the first time since 2013/14. Similarly, forces are increasing their focus on sexual assaults, while aiming to reduce the amount of time spent on non-crime demands such as responding to mental health incidents.

However, there is considerable uncertainty about the long-term impact of the additional officers. Forces are under financial strain to maintain officer numbers, while rapid recruitment has led to concerns over the adequacy of vetting arrangements and the burden placed on supervising officers. It will take time to assess whether these changes can lead to a sustained increase in the number of charges, and improvements in public trust.

* The figure shown is the 'minimum' as Devon & Cornwall Police did not submit full data in 2022/23.

Police forces have seen big funding increases in recent years

Figure 7.1 Spending on police, 2009/10–2022/23 (2023/24 prices)



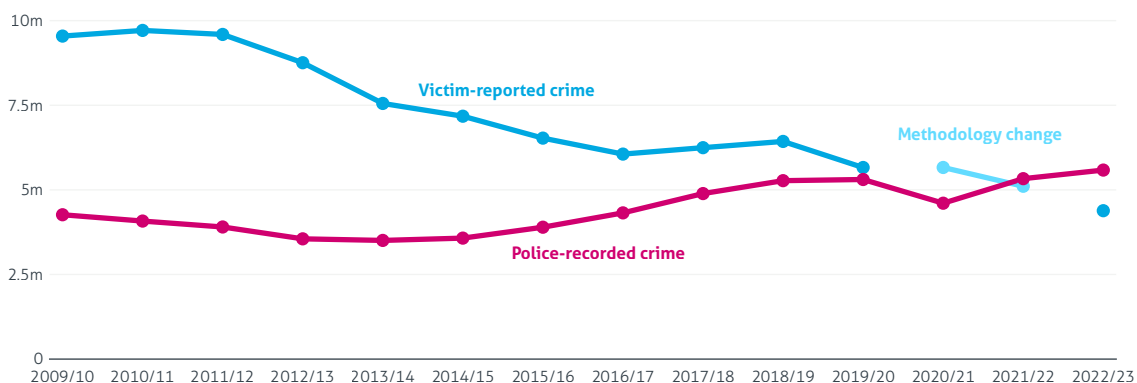
Source: Institute for Government analysis of DLUHC, 'Local authority revenue expenditure and financing England: 2022 to 2023 outturn - first release' ('Table 3a') and StatsWales, 'Police authority budget requirement by police', 2022/23, supported by CIPFA. Notes: See Methodology for details of how figures have been put into real terms.

Around 70% of police funding comes from central government.¹ Most of that is passed directly to police and crime commissioners (PCCs), who have broad control over how much is allocated to their force as opposed to other services such as victim support.² The rest of the central funding goes to support national efforts like counter-terrorism.³ The other major funding source is the police precept on council tax.⁴ This is set by each PCC and since 2015/16 has accounted for between 25% and 30% of annual police funding.⁵

Police expenditure declined in real terms by 16.2% between 2009/10 and 2016/17. It has risen significantly in recent years – although remains below 2009/10 levels – with real-terms spending sitting at £17.3bn in 2022/23. One key driver of these recent increases has been the government's 2019 police uplift programme to increase officer numbers by 20,000, which the National Audit Office (NAO) expected would cost £3.6bn by 2023. In 2022/23, the government provided an additional £550m to PCCs in part to help forces recruit their quota of additional officers,⁶ and also allowed them to raise up to £246m through increases to the police precept.⁷

Overall crime is at historic lows

Figure 7.2 Incidents of crime excluding fraud and computer misuse, 2009/10–2022/23



Source: Institute for Government analysis of ONS, 'Crime in England and Wales: Appendix tables' ('Worksheet A1' and 'Table A4a'), 2022/23, supported by CIPFA. Notes: Police-recorded crime figures in 2019/20 exclude those from Greater Manchester Police, which was unable to supply data for the period July 2019 to March 2020. Victim-reported crime figures for 2022/23 are comparable to those for 2019/20 and earlier (although National Statistics status for estimates were temporarily suspended in July 2022 due to data quality concerns). Details of the methodology change, affecting 2020/21 and 2021/22, are described in the Methodology chapter.

Our understanding of crime levels comes from two sources:

- **Police-recorded crime statistics:** these statistics come from the crimes reported to – and recorded by – the police. They provide a relatively quick signal of emerging trends, but are influenced by changing recording practices, police activity and public willingness to report crimes.⁸
- **The Crime Survey for England and Wales (CSEW):** conducted by the Office for National Statistics (ONS), this looks at crimes reported by a representative population sample. It measures a smaller number of crimes than police-recorded statistics, but captures crimes not reported to the police and is independent of police recording practices. As such, the CSEW is a better indicator of long-term trends.⁹

The CSEW has shown a relatively consistent decline in the number of crimes over the last decade. In 2022/23 this was at its lowest level at 4,384,656 crimes.* This is a 22.5% decline on 2019/20, the most recent year for which comparable data is available. The key contributors to this trend have been declines in theft and violence offences.

Conversely, the levels of police-recorded crime have been increasing in recent years and are now well above levels recorded by the CSEW. Overall police-recorded crime stood at 5,584,888 in 2022/23, some 30.9% above 2009/10 levels and 59.3% above 2013/14 levels.** Contributing to this increase is a growth of 204% in recorded sexual offences between 2013/14 and 2022/23, and a 233% increase in total 'violence against the person' offences over the same period.

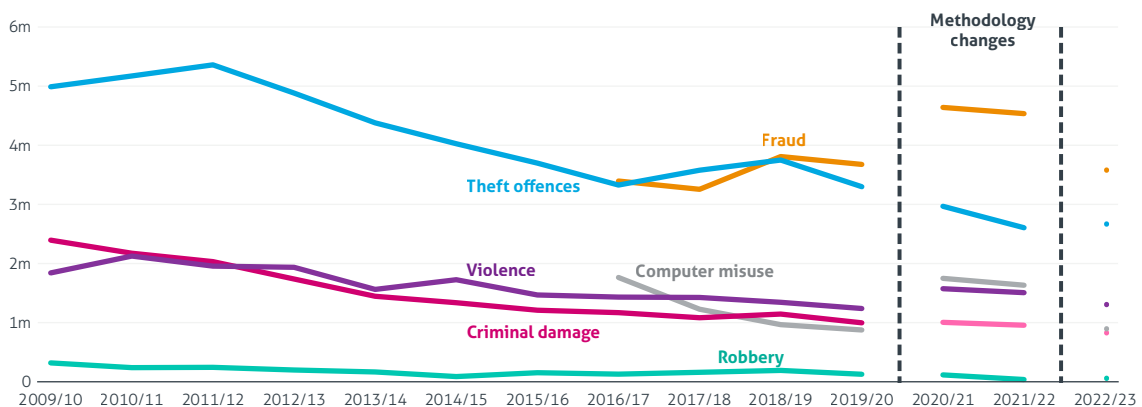
* Excluding fraud and computer misuse.

** Excluding fraud and computer misuse.

It is likely that overall crime has declined, while changes in reporting and recording practices largely explain the growth in police-recorded crime.* However, both the police-recorded statistics and CSEW measures agree on the trends for some crimes. For example, aside from a pandemic-led uptick in 2020/21, police-recorded incidents of anti-social behaviour (ASB) have declined consistently every year since at least 2007/08.¹⁰ The 1,006,197 incidents recorded in 2022/23 stands 25.4% below pre-pandemic levels, and 71.5% below 2009/10 levels.**¹¹ This seems to correspond with the CSEW, which has recorded a relatively consistent decline in perceptions of high levels of anti-social behaviour since 2006/07.¹²

Fraud and computer misuse now account for half of all crime

Figure 7.3 Victim-reported crime by type, 2009/10–2022/23



Source: Institute for Government analysis of ONS, 'Crime in England and Wales: Appendix tables' ('Worksheet A1'), 2009/10–2022/23, supported by CIPFA. Notes: Fraud figures have only been recorded since October 2015. Figures for 2022/23 are comparable to those for 2019/20 and earlier (although National Statistics status for estimates were temporarily suspended in July 2022 due to data quality concerns). Details of the methodology change, affecting 2020/21 and 2021/22, are described in the Methodology chapter.

In recent years, digital technology has provided new opportunities for criminals to engage in cyber-crime. According to the CSEW, there were 4.27m fraud and computer misuse offences in 2022/23. The total number of fraud and computer misuse cases has actually fallen by 17.2% since 2016/17, when they were first recorded. However, as a result of a decline in other case types, fraud and computer misuse now account for half of all victim-reported crime (49.3%).

Despite the scale of fraud, the Police Foundation (a policing think tank) has been critical of forces' response to it.¹³ The absolute number of charges or summonses for fraud has declined by 39% since 2016/17 and in 2022/23 only 0.35% of all reported fraud (which itself is a small proportion of the CSEW figure) resulted in a charge or summons.¹⁴ This partly reflects that a large proportion of fraud incidents either originate abroad or have an international element.

* Excluding fraud and computer misuse.

** Figures exclude British Transport Police.

Non-crime demand takes up a significant amount of police time

In addition to responding to crimes, the police also undertake a large amount of non-crime work. This includes demands from mental health, public protection, safeguarding and missing persons activity.

Forces do not measure non-crime demand consistently but it certainly takes up a large amount of police time. For example, in 2015, the vast majority of calls to the police did not result in a crime being recorded (83%),^{*15} while one study estimated that around 20% of front-line police resource is allocated to incidents requiring mental health engagement.¹⁶

There is also some evidence that non-crime demand is growing. For example, 21 of the 48 forces which responded to a recent Freedom of Information (FOI) request reported a rise in mental health incidents since 2017, with one force reporting a 313% rise.¹⁷ Cases of detention under the Mental Health Act increased by 36% between 2016/17 and 2021/22.^{18,**} This has been linked to reductions in funding for mental health services.¹⁹ Similarly, the number of missing persons incidents, which increased by 65% between 2013/14 and 2019/20, has been estimated to cost the police around 3m investigation hours each year.²⁰

Noting that the police often stray into doing the work of other services, the police inspectorate (HMIC) recently argued that “there needs to be greater clarity over what the police’s role in society is”.²¹ The recent ‘Right Care, Right Person’ initiative – which partly seeks to reduce the amount of time police spend on mental health callouts – is one such effort, but its success will take time to evaluate.²²

The number of charges increased sharply in 2022/23 for the first time since 2013/14

Charge rates – that is, the proportion of recorded crimes that resulted in a charge – have declined precipitously over the last decade. This is partly a function of the increase in the number of crimes recorded by the police and in some cases the *over*-recording of crimes. Recently announced changes to recording practices, which will involve recording fewer crimes (including minor offences committed in the course of a more substantial offence) will likely reduce the number of recorded crimes and increase the charge rate.²³

However, the absolute number of charges issued each year also fell by 43.6% between 2009/10 and 2021/22. This fall likely reflects problems with police performance. Last year, HMIC argued that insufficient supervision, poor digital forensic capability and inadequate capacity had contributed to low charge rates for serious acquisitive crime.²⁴ HMIC also criticised what it described as the “unacceptably low number of crimes that are solved following investigations”, and identified cases in which investigations were closed before all lines of inquiry had been pursued.²⁵ Indeed, HMIC’s PEEL inspections (which examine the effectiveness of forces) assessed no forces as outstanding when it came to investigating crime.²⁶

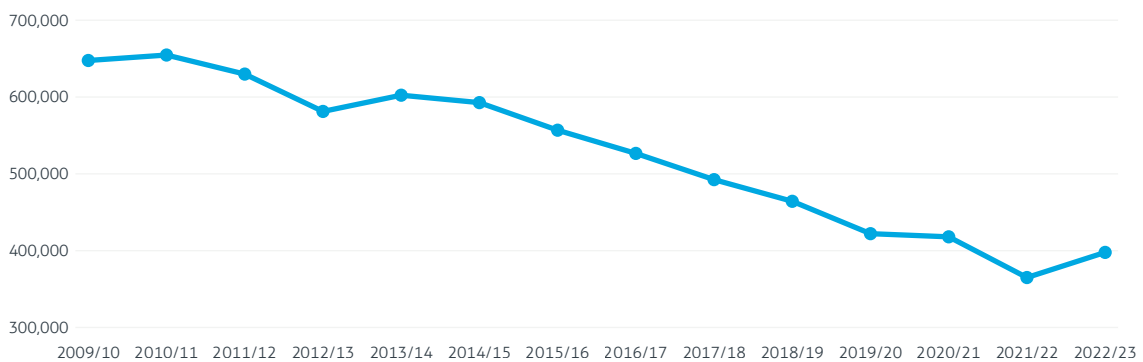
* The 83% of calls will, however, include crime-related incidents where no crime was recorded.

** For comparability, Avon & Somerset, North Wales, and West Mercia have been excluded.

The police have come under particular scrutiny for their performance in charging sexual assault and rape. In 2014/15, just 11.3% of sexual assaults and 8.5% of rapes ended up being charged. In 2021/22 this had fallen to 2.9% and 1.3% respectively. The government’s end-to-end rape review highlighted forces’ poor performance against rape investigations.²⁷

Similarly, Operation Soteria (a pathfinder programme seeking to identify ways to transform investigations into sexual offences, and now being rolled out to all forces) has found that investigators lack sufficient knowledge about sexual offending, that disproportionate effort was being put into testing the credibility of a victim’s accounts, and that forces lack sufficient data systems to allow for good strategic analysis to improve investigations.²⁸

Figure 7.4 **Charges/summons recorded by police forces, 2009/10–2022/23**



Source: Institute for Government analysis of Home Office, 'Crime outcomes in England and Wales' ('Table B2'), 2022/23, and Home Office, 'Police recorded crime and outcomes open data tables', 2018/19–2022/23, supported by CIPFA. Note: Greater Manchester Police and Devon & Cornwall Police did not submit full data in 2019/20 and 2022/23 respectively.

The charge rate rose marginally in 2022/23 to 5.7%, up from 5.5% the year before. The increase in 2022/23 was the result of a minimum 8.9%* increase in the absolute number of charges. This is the first increase in the absolute number of charges since 2013/14. As discussed further below, the increase in the number of charges likely reflects new officers becoming more productive. This was in part driven by a 23.9% (minimum) increase in charges for sexual offences, the largest year-on-year increase since at least 2006/07.

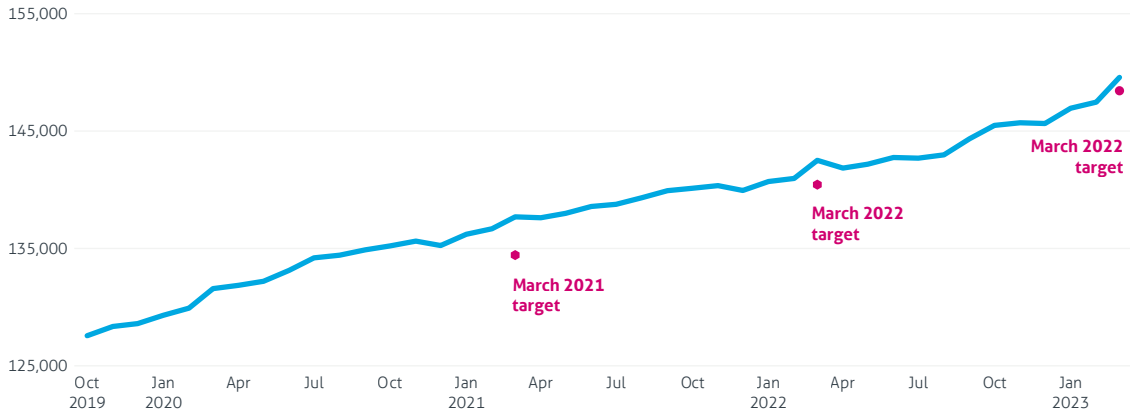
While this likely reflects the efforts inspired by Operation Soteria, the charge rate for sexual offences only increased marginally to 3.6%, significantly below the 2013/14 level. Similarly, overall charges are still at historic lows, and it will take time before forces can demonstrate consistent overall improvements.

* Devon & Cornwall Police did not submit full data in 2022/23.

The government has met its officer recruitment target

In 2019, the government announced the police uplift programme, its plan to increase officer numbers by 20,000 by March 2023. The government has now successfully met this target, increasing officer headcount by 20,947 compared to October 2019. Accounting for attrition, this involved recruiting 46,504 new officers, approximately 31% of the total officer workforce.²⁹

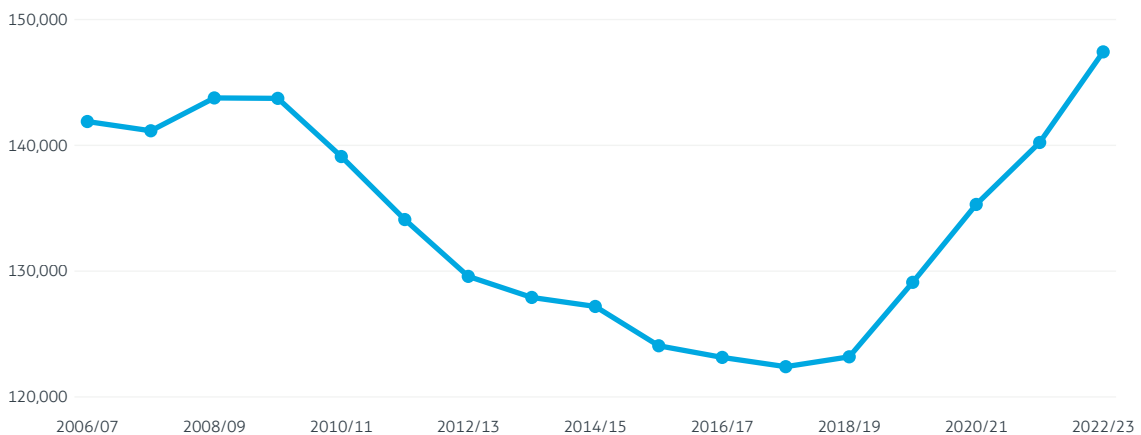
Figure 7.5 Police officers (headcount), October 2019 to March 2023



Source: Institute for Government analysis of Home Office, 'Police officer uplift, final position as at March 2023' ('Table U1'), October 2019 to March 2023, supported by CIPFA. Note: Figures are shown from the beginning of the police uplift programme and include both police officers recruited through the programme and those recruited through other streams.

This has contributed to a 14% increase in full-time equivalent (FTE) officer numbers since 2019/20. This is the highest number of officers since at least 2002/03, when comparable records began.³⁰ The recruitment has also accelerated the long-term growth in the proportion of female officers since 2006/07 (women now comprise 35% of all officers compared to 30% in 2018/19 and 23% in 2006/07). It has also had an impact on overall ethnic diversity, with the proportion of non-white officers increasing from 9.3% to 11.0% between 2018/19 and 2022/23.

Figure 7.6 Police officers FTE, 2006/07–2022/23



Source: Institute for Government analysis of Home Office, 'Police workforce, England and Wales, 31 March 2023: workforce open data tables', supported by CIPFA. Note: Figures exclude the British Transport Police.

The police uplift programme may help address key shortages, but also poses several challenges

The roles that new officers are put into will make a big difference to whether the number of charges continues to increase in future years. Interviewees repeatedly stressed concern over the national shortage of detectives. In 2021, there was a shortfall of 6,851 level 2 accredited investigators (dealing with the most complex investigations), a 38% increase on the previous year.³¹ A lack of suitably qualified detectives can damage both the quantity and the quality of police investigations.³²

Similarly, concerns have been raised about the ability of forces to properly manage and investigate serious acquisitive crime (burglary, robbery and theft),³³ and mismatches between the increasing demand for digital forensic examinations and forces' capacity in this respect.³⁴ It appears that the police uplift programme has already contributed to an increase in officers undertaking these roles, with 2,376 additional officers working in investigations in 2022/23 compared to 2018/19. This may explain why the number of charges per officer increased to 2.7 in 2022/23, from 2.6 a year earlier.* This is the first increase since 2013/14, which recorded 4.7 charges per officer. If, as newly deployed officers become fully effective, this figure continues to grow, then this will feed through into a sustained increase in the number of charges as well.

In the short term, new officers are a drain on the productivity of more senior colleagues. Before being able to work independently, new officers require supervision by more experienced 'tutor constables'. In one survey, the NAO found that these responsibilities may make tutors up to 50% less operationally effective, citing tutor 'burnout' as a problem.³⁵ This may have damaged the overall effectiveness of the workforce, as might some of the methods forces have employed to manage this pressure, including giving tutoring responsibilities to less experienced officers and increasing the number of students per tutor.³⁶ The Police Remuneration Review Body has reported that some officers became supervising sergeants after two years of service, leading to concerns that a lack of support would undermine morale and cause retention problems.³⁷

There is also evidence that the police uplift programme may have had a negative impact on the composition and thus the performance of police workforces. Officers are supported by other police staff who, as of 2022/23, made up approximately 31% of the total police workforce and include administrators, trainers and investigators. In recent years, these roles have been increasingly occupied by civilian – thus more cost-effective – specialists.³⁸ However, the requirement to maintain officer numbers has incentivised forces to replace cheaper staff – who often have specialist skills – with more expensive warranted officers.³⁹

Despite the overall increase in officer numbers in recent years, the number of police community support officers (PCSOs) declined by 15.6% from 2019/20 to 2022/23. Over this period, many were recruited into the uplift programme. The reduction in PCSOs – whose numbers had already fallen by 45.3% between 2009/10 and 2019/20

* As above, this excludes some data from Devon & Cornwall Police. As such, the number of charges per officer is probably slightly higher.

– has been cited as a key contributor to the decline in community engagement between forces and citizens.⁴⁰ While recent recruitment has boosted the number of neighbourhood officers, this has failed to translate into, for example, greater police visibility, perceptions of which reached their lowest recorded level in 2022/23.⁴¹ This has occurred over a period in which the demands on local policing have intensified, and has contributed to worse outcomes with respect to community engagement, preventative proactivity and visibility.⁴² Indeed, to the extent that the new constables are performing neighbourhood policing roles, this is inefficient, since PCSOs are cheaper to employ than warranted officers.

Finally, concerns have also been raised over the adequacy of the system for vetting police recruits, which has recently led the College of Policing to strengthen its vetting Code of Practice.⁴³ Concerns that high recruitment demand would place vetting units under substantial pressure were raised at the start of the uplift programme in 2019.⁴⁴ Despite these warnings, HMIC recently found that vetting units have struggled to cope with their higher caseload.⁴⁵ Indeed, HMIC concluded that hundreds of people had likely joined the police in the last few years who should not have.⁴⁶ Similarly, recruiting difficulties and pressure to meet the target have sparked concerns that recruitment practices may have been simplified.⁴⁷ The recruitment of potentially large numbers of unsuitable officers could have a long-term impact on police performance and trust in the police.

Public trust in the police is falling

The case of David Carrick, who in December 2022 pleaded guilty to 49 offences (including rape) committed over a long career as an officer in the Metropolitan Police, is one of a litany of scandals that have rocked public confidence in the police in recent years. Others – including the murder of Sarah Everard, child strip searches and the Charing Cross scandal – have similarly cast doubt on the police’s ability to appropriately vet and discipline officers (including those with histories of misconduct) and, ultimately, protect the public. This was particularly true of the aftermath of the Carrick case, when it was revealed that over 1,000 allegations of sexual misconduct implicating 800 officers had been spotted by the Met.⁴⁸ More recently, the Met has revealed large increases in the number of officers dismissed for gross misconduct, awaiting gross misconduct hearings, or who have been suspended.⁴⁹

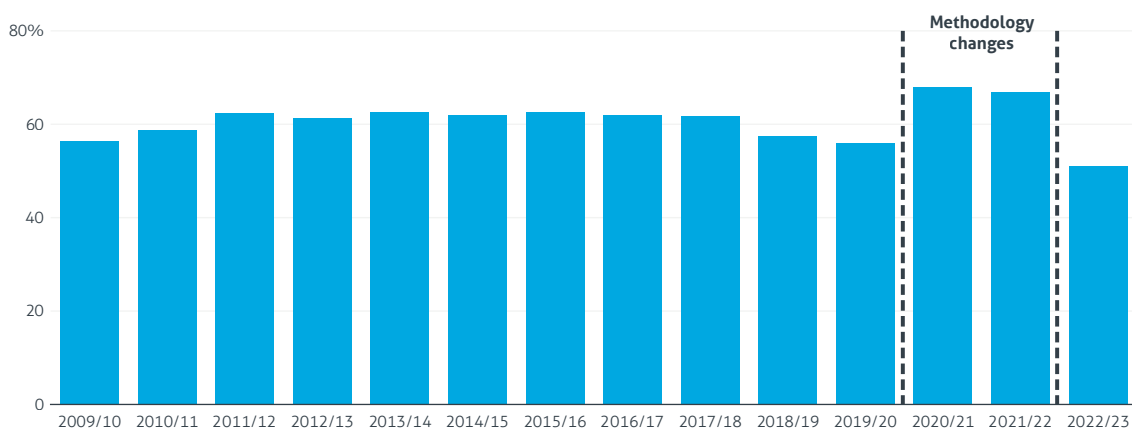
Most of this attention is focused on the Met, which Baroness Casey – in her recent review into behaviour and standards in the Met – labelled institutionally racist, homophobic and sexist.⁵⁰ However, along with the Met, another three forces are also in ‘special measures’,⁵¹ an advanced monitoring process for forces not responding to – or unable to deal with – concerns identified by HMIC.⁵² Similarly, there is evidence that claims of sexual misconduct and racism are proportionally higher in several other forces.

These reports have likely contributed to the marked decline in trust in the police among people from minority ethnic backgrounds in particular. One survey from the Mayor’s Office for Police and Crime (covering London) reported that the proportion of Black respondents who believe that the police treat everyone fairly regardless of who they are fell from 64% in 2019/20 to 46% in 2021/22 (having been relatively stable

since 2014/15). While such surveys in London consistently display lower rates among Black than White respondents, it is notable that the same survey also displayed a marked – though smaller – decline among White British respondents from 2019/20.⁵³

Trust in the police among the general population is also declining. The share of CSEW respondents reporting that their local police are doing a good or excellent job fell by 5 percentage points between 2019/20 and 2022/23, to 51%. This is down from 63% in 2015/16. Interestingly, the ethnic groups with the largest proportion claiming the police are doing a good or excellent job are Asian, Black and Other ethnic groups. Respectively, 59%, 56% and 63% of the respondents in these groups believed their local police were doing a good or excellent job in 2022/23, compared to 50% of White respondents.⁵⁴

Figure 7.7 **Perception that local police are doing a good or excellent job, 2009/10–2022/23**



Source: Institute for Government analysis of ONS, 'Crime in England and Wales: annual supplementary tables' ('Table S1'), March 2023, and ONS, 'Crime in England and Wales: coronavirus (COVID-19) and crime tables' ('Table 5'), July 2022, supported by CIPFA. Note: Details of the methodology changes are explained in the Methodology chapter.

Overall, data from YouGov indicates a marked loss of confidence in recent years. Averaging figures over a 12-month period in a survey carried out between October 2022 and September 2023, more than half of respondents said they had either not very much or no confidence at all in the police to deal with crime (52%), compared to 48% in the previous 12-month period.⁵⁵ Similarly, in a different survey, averaged figures over the same period showed that half of respondents felt the police were doing a good job compared to 60% a year earlier.⁵⁶



8. Criminal courts



Crown Court
Crown Court



Criminal courts: key figures

- **£2.3bn** – the amount spent on HM Courts and Tribunals Service in 2022/23 – 8.6% lower than 2021/22
- **64,709** – the size of the crown court backlog in June 2023 – compared to 40,826 in March 2020, making it the highest figure ever recorded
- **28.3%** – the proportion of all cases that have been waiting in the crown court system for more than a year – compared to 7.2% in March 2020
- **17.5%** – the average proportion of 'ineffective trials' in the magistrates court since September 2020 – 4.2% percentage points higher than the average ineffectiveness rate between 2010 and 2020
- **41%** – the size of the real-terms decline in criminal legal aid spending since 2011/12

Introduction

The twin effects of the pandemic and the 2022 barristers' strike have severely affected the functioning of the criminal courts in recent years, with hearings delayed and the case backlog growing to record highs.

Magistrates' courts have made good progress in starting to clear their backlog. This is a reflection of the largely procedural nature of many of the minor cases that enter these courts, also helped by the decline and slow growth in demand at the start of the pandemic.

The situation in the crown court – which conducts more serious or complex hearings and, crucially, jury trials – is much worse. Its case backlog reached a record 64,709 in June 2023. Adjusted for the complexity of cases in the backlog, which disproportionately comprises jury trials, this was equivalent to 89,937 cases. The backlog grew initially due to Covid-enforced court closures and social distancing, and then again in 2022 due to industrial action by criminal barristers.

These were exceptional events, but courts dealing with the most serious cases have also faced wider problems translating higher spending and more sitting days in recent years into greater throughput. As such, the crown court is facing a productivity crisis that has continued to increase the backlog. This has increased waiting times, with 28% of cases in the backlog waiting for over a year, and 10% waiting over two years. With demand projected to increase, this must change if backlogs are to be cleared and the court system is to operate efficiently.

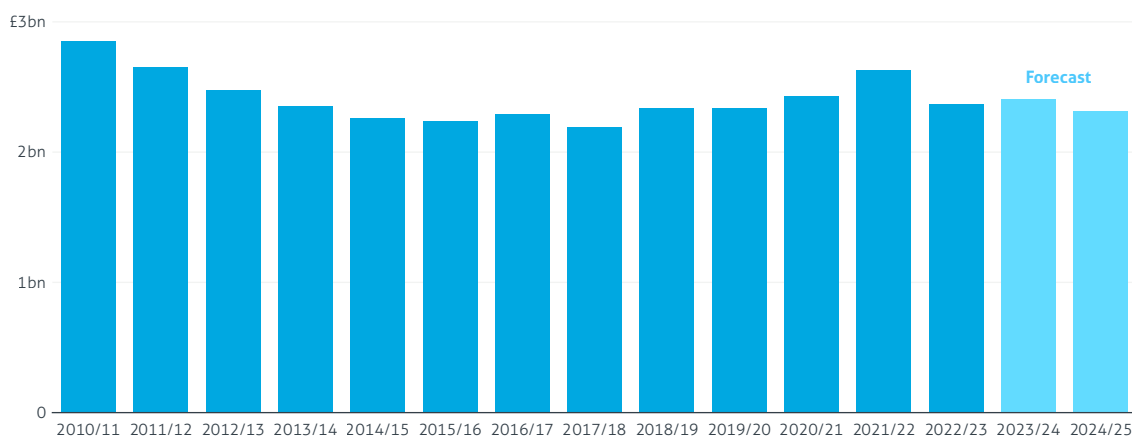
Spending fell in 2022/23, and is set to continue falling

Real-terms spending on courts in England and Wales declined by 23.4% between 2010/11 and 2017/18. It then increased by 20% between 2017/18 and 2021/22, before falling by 10% in 2022/23.

The fall in 2022/23 is largely explained by a fall in non-cash expenditure – which includes provisions for future spending – with real-terms spending also eroded by high levels of inflation. Spending on the judiciary and staff fell by 3.4% in 2022/23.

Under the 2021 spending review, real-terms spending on courts (criminal and civil) was set to increase by around 4% per year to 2024/25.¹ However, higher than expected inflation means that courts' spending is now expected to *fall* by 2% in real terms between 2022/23 and 2024/25. (Unlike the NHS, schools and adult social care, criminal justice services were not provided with additional funding in the autumn statement 2022 to account for inflation.)

Figure 8.1 **Spending on HMCTS, 2010/11–2022/23 (2023/24 prices)**



Source: Institute for Government analysis of HMCTS annual reports and accounts from 2010/11–2022/23, supported by CIPFA. Notes: Figures are only available from 2010/11. See Methodology for details of how figures have been put into real terms.

Demand is lower than before the pandemic in the magistrates but higher in the crown court, and is likely to rise in coming years

The best way to measure demand in criminal courts is to look at the number of cases they receive. All cases start their life in the magistrates' courts; the most serious are then passed on to the crown court.

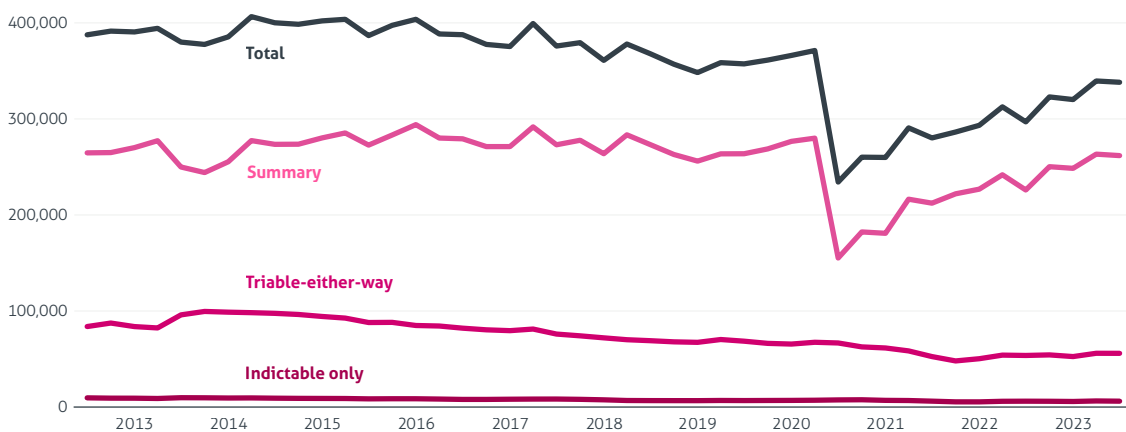
The number of new cases entering the magistrates' court fell by 6.9% between 2012/13 and 2019/20. There was then a further, dramatic, fall in new cases in Q2 2020 with the onset of the pandemic (down 36.9%). Since then, demand has slowly increased but the number of cases received in 2022/23 was still 12.1% lower than in 2019/20. It is also lower than was implied by the government's own model for the impact that the increase in the number of police officers would have on court demand. However, as discussed in the Police chapter, the number of charges increased by at least 8.9% in 2022/23. This is likely to lead to more cases entering the courts in future years.

Criminal cases are split into three main categories:

- **summary**: the least serious case type, comprising the vast majority of new cases
- **either-way**: cases whose severity means they can be processed in either the magistrates' or crown court
- **indictable only**: the most serious cases, which can only be heard in the crown court

The pre-pandemic decline in new cases was driven by declines of 20.6% and 25.3% in more serious 'either-way' and 'indictable' cases (respectively) from 2012/13 to 2019/20. This was a consequence of fewer charges, increasing crime complexity and cuts in the Crown Prosecution Service's budget. The decline in indictable cases also explains the decline in crown court demand. However, at the end of 2021 the trend of falling numbers of 'either-way' cases was reversed. The number of 'either-way' cases received by the magistrates' courts grew by 16.5% between Q3 2021 and Q2 2023.

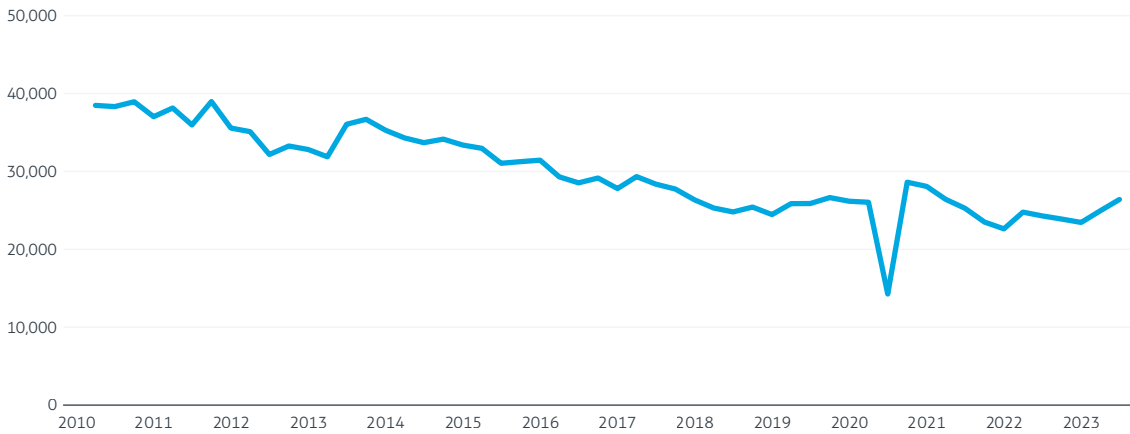
Figure 8.2 **Cases received by magistrates' courts, Q2 2012 to Q2 2023**



Source: Institute for Government analysis of MoJ, 'Criminal court statistics, April-June 2023' ('Table M1'), supported by CIPFA. Notes: Data is only available from 2012/13. For legibility, we have excluded breaches from this chart, although they are included in the total.

Before the pandemic, demand in the crown court fell more dramatically than in magistrates' courts. In 2019/20 annual crown court receipts were 31.3% lower than in 2010/11. A sharp 45.2% drop at the start of the pandemic quickly recovered in the second half of 2020, and demand in 2022/23 was only 7.8% below the 2019/20 level. However, a more recent spike in crown court receipts – equating to a 13% growth since December 2022 – means demand has now surpassed pre-pandemic levels. This is partly attributable to a surge of cases following the reversal of magistrates' extended sentencing powers – a measure that was introduced to relieve pressure on the crown court but which subsequently raised concerns about prison capacity. We expect this trend to continue, however, given the recent increase in charges.

Figure 8.3 Cases received by the crown court, Q1 2010 to Q2 2023



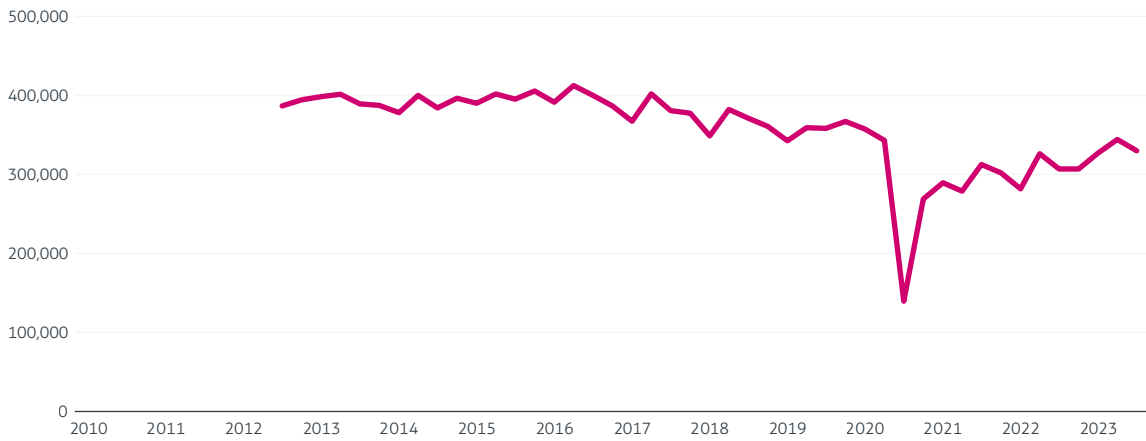
Source: Institute for Government analysis of MoJ, 'Criminal court statistics (quarterly): January to March 2020' ('Table C1') and 'Criminal court statistics, April-June 2023' ('Table C1'), supported by CIPFA. Note: Pre-2014 data based on a different reporting system so the numbers are not exactly comparable.

Nor do the headline numbers tell the full story. The complexity of cases entering the crown court has also increased. For example, sexual offences – which require complex evidence handling and more sitting days, and have lower guilty plea rates than many other offences – comprised 10.3% of all the cases entering the crown court in Q2 2023. This proportion has been rising since Q2 2018, when such cases comprised 5.7% of cases – a 93.9% increase between these quarters. More broadly, the proportion of *all* defendants who plead not guilty (or enter no plea) was 26.9% in 2022/23, the highest level since 2018/19.² This too has pushed up the average length of trials.³

Courts have struggled to process more cases and are less efficient

At the start of the pandemic, the combination of lockdowns and social distancing requirements severely limited courts' ability to process cases, particularly jury trials. In the second quarter of 2020, the magistrates' courts dealt with 59.3% fewer cases than the preceding quarter. Following this initial shock, magistrate courts gradually increased the number of cases processed, with the number in Q1 2023 just 3.8% lower than in Q1 2020. The magistrates' courts were hampered by several strikes among legal advisers and court associates over the rollout of the Common Platform⁴ – a digital case management system that forms a key part of HMCTS' reform programme⁵ – from September 2022 to March 2023. Despite this, they have processed more cases than they have received in most quarters since the start of the pandemic.⁶

Figure 8.4 Cases processed by magistrates' courts, Q2 2012 to Q2 2023

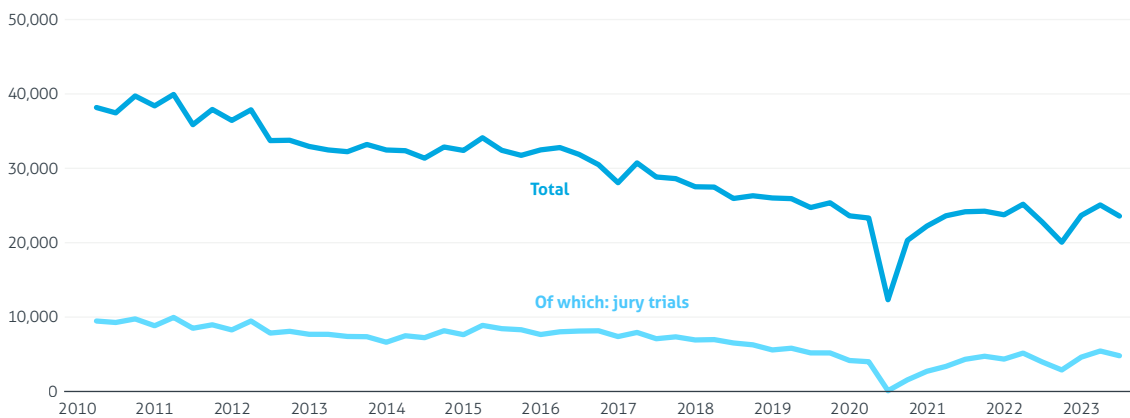


Source: Institute for Government analysis of MoJ, 'Criminal court statistics, April-June 2023' ('Table M1'), supported by CIPFA. Note: Quarterly data is only available from 2012.

In the crown court, processing was limited by the dual effects of the pandemic and the barristers' strike. The pandemic initially caused a sharp 47.1% drop in the total number of cases that crown courts processed, including an almost total 97.5% fall in jury trials. After quickly recovering, last year's industrial action had a further negative effect, causing a 20.2% drop in the number of cases processed between Q1 and Q3 2022.

Even outside of these crises – and despite increased funding since 2017/18 and an increase in sitting days (discussed below) – the number of cases processed has not surpassed pre-pandemic levels, and it declined in the most recent quarter. This suggests courts are operating less efficiently than in the past.

Figure 8.5 Cases processed by the crown court, Q1 2010 to Q2 2023



Source: Institute for Government analysis of MoJ, 'Criminal court statistics (quarterly): January to March 2020' ('Table C1') and 'Criminal court statistics, April-June 2023' ('Table C1', 'Table C2'), supported by CIPFA. Note: Pre-2014 data based on a different reporting system so the numbers are not exactly comparable.

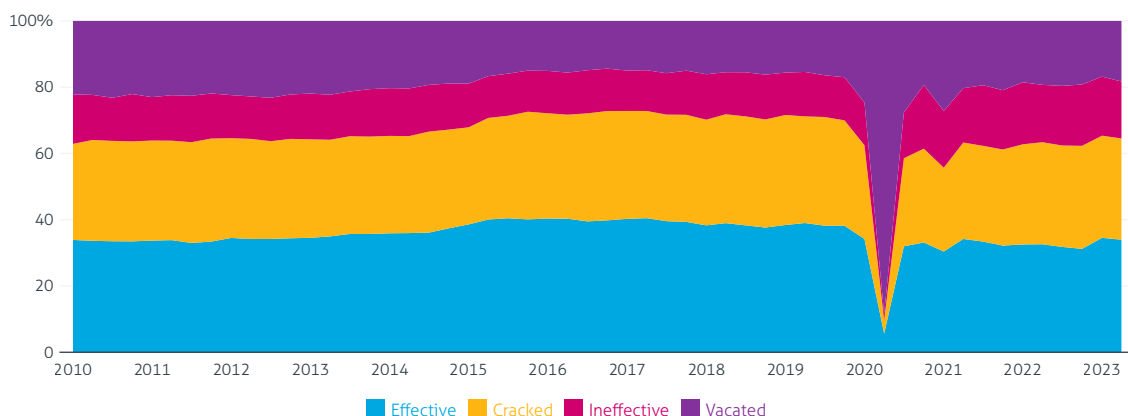
Several factors are contributing to this drop in productivity

One reason courts have struggled to process as many cases as they did before the pandemic is that they have become less efficient. The Ministry of Justice records all court cases that are listed for trial as having four potential outcomes:

- **effective:** the trial goes ahead as planned
- **vacated:** the trial is postponed ahead of the scheduled date (meaning another case can be listed instead)
- **cracked:** the trial does not need to go ahead, but this is only decided on the day
- **ineffective:** the trial does not happen on the day and must be rescheduled.

Since the pandemic, one of the most concerning trends has been the growth of ineffective cases in criminal courts. This is the worst outcome as far as efficiency is concerned, as it means court space goes unused while legal practitioners spend time preparing for cases that do not happen. In the magistrates' courts, the proportion of ineffective trials averaged 13.3% per quarter from 2010 to 2020, compared to 17.5% since Q3 2020.

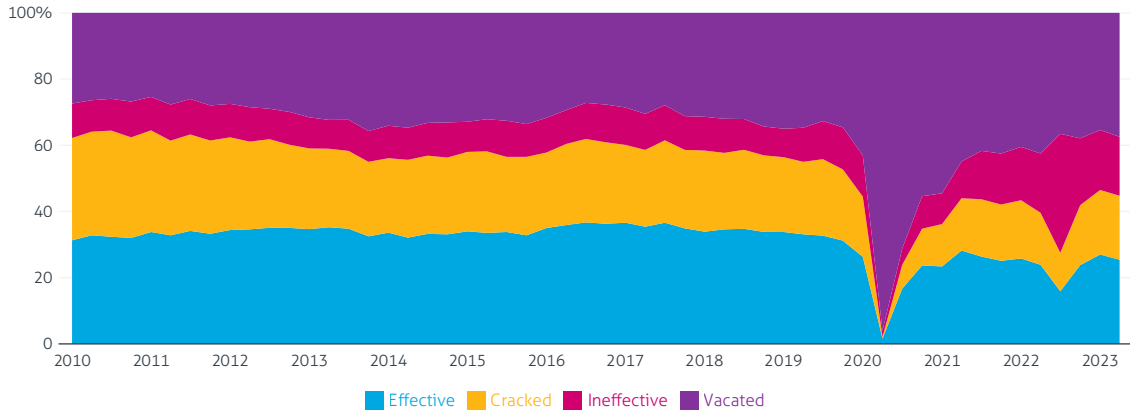
Figure 8.6 Trial effectiveness in magistrates' courts (Q1 2010 to Q2 2023)



Source: Institute for Government analysis of MoJ, 'Criminal court statistics, April-June 2023' ('Table M2'), supported by CIPFA. Notes: In official statistics, vacated trials are excluded from the denominator of effective trial statistics. However, we include them to show how prevalent this event is. Some trials recorded as vacated will have been scheduled for a later quarter.

The situation is worse in the crown court, where quarterly rates of ineffectiveness averaged 18.6% from Q2 2021 to Q2 2023, up from 10.2% between 2010 and 2019. At the height of the barristers' strike, such cases comprised a record 35.9% of all listed trials, driven by the unavailability of defence advocates. While the strike was the immediate cause of this, interviewees have stressed concern over the unavailability of legal advocates as a growing contributor of ineffectiveness; this was also cited by the Lord Chief Justice as a cause of court efficiency problems in 2021 and 2022.⁷ Contributors to this have included the decline in sitting days – the number of days that the government funds for judges to hear cases – over several years and the poor relative remuneration of criminal legal work, both of which have reduced the market for criminal legal work. Interviewees stressed that reducing sitting days in particular has pushed barristers and solicitors into other areas of legal work.

Figure 8.7 Trial effectiveness in the crown court (Q1 2010 to Q2 2023)



Source: Institute for Government analysis of MoJ, 'Criminal court statistics, April-June 2023' ('Table C2'), supported by CIPFA. Notes: In official statistics, vacated trials are excluded from the denominator of effective trial statistics. However, we include them to show how prevalent this event is. Some trials recorded as vacated will have been scheduled for a later quarter.

Problems with buildings and technology have also reduced court efficiency. The Law Society has raised concerns over problems with the suitability of courts' facilities⁸ while the Bar Council has described instances in which leaks, infestations and collapsing walls have blighted court space.⁹ However, these issues have had less impact than the insufficiency of the workforce to make use of existing space.¹⁰

Similarly concerning is courts' inability to make use of available sitting days. The government (which funds sitting days) began to reduce the number of sitting days from 2015, and Covid restrictions reduced these further in 2020 to the lowest recorded level (69,100 compared to 113,800 in 2015).¹¹ Sitting days have since grown to 102,600 in 2022. However, the amount of time spent hearing cases has been much lower since the onset of the pandemic; 2.7, 2.9 and 2.8 hours per sitting day in 2020, 2021 and 2022 respectively, compared to 3.6, 3.5 and 3.5 hours in 2017, 2018 and 2019 respectively.

This means courts are making less use of the available time. Covid restrictions may have played a part in this, as courts listed cases less aggressively than in the past (meaning that when cases were cracked, there was often no other case to take its place).¹² Similarly, greater use of remote hearings – scheduled for specific times – may be extending the time between hearings, leading to less efficient use of sitting days.

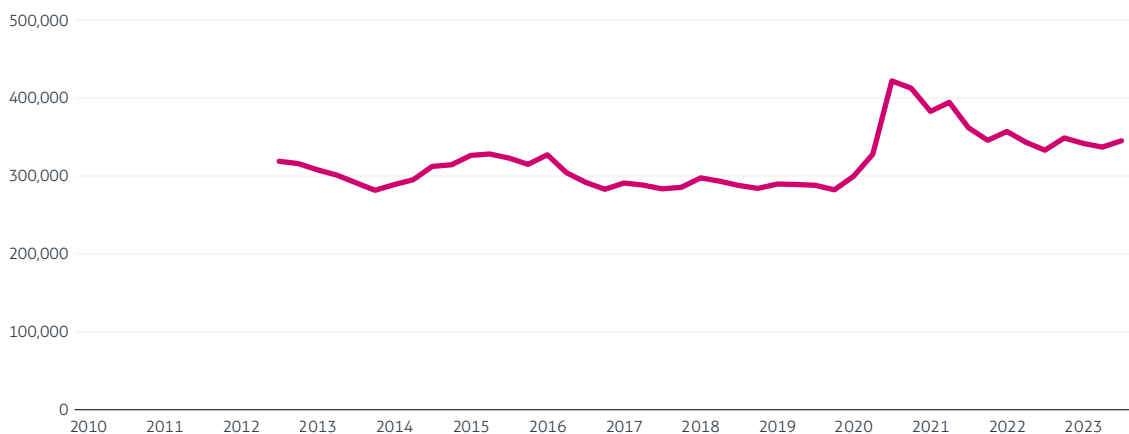
The increased complexity of cases may also have exacerbated listing problems. These cases have less predictable lengths, and it is harder to schedule cases to make best use of sitting days when a greater proportion of cases are unpredictable in this way. Concerningly, given our expectation that the number of complex cases will continue increasing, this means that productivity may continue to decrease.

This declining efficiency, coupled with rising demand, has led to the crown courts receiving more cases than they have been able to process for the last four years and the size of the case backlog growing dramatically.

A huge crown court backlog will continue to hamper the smooth functioning of the service

In the magistrates' courts, the backlog reached 422,156 cases in Q2 2020, some 40.8% higher than in December 2019 and the highest since the data was first published in 2012. Magistrates' courts processing capacity has grown more quickly than the growth in demand since 2020 and as a result, the backlog has been cut by 18.2% and is now 15.2% higher than in December 2019. Several factors have contributed to this. First, many cases are less complex, allowing greater use of remote hearings. Second, many cases can be heard with a single magistrate and legal adviser (the single justice procedure).

Figure 8.8 Case backlog in magistrates' courts, Q2 2012 to Q2 2023



Source: Institute for Government analysis MoJ, 'Criminal court statistics, April-June 2023' ('Table M1'), supported by CIPFA. Note: Quarterly data is only available from 2012/13.

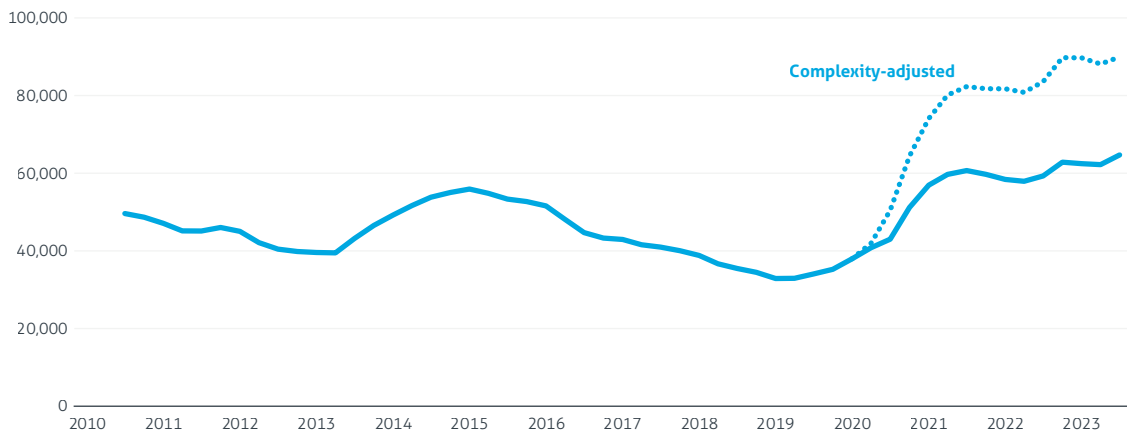
If defendants plead not guilty, cases in the crown court require jury trials. These became more difficult to conduct during the pandemic, meaning the crown court was more substantially affected by the pandemic than the magistrates courts were. Indeed, were *no* additional cases to enter the court system, the current magistrates' backlog could be cleared in less than three months; the estimate for the crown court is more than seven months.

The number of cases waiting in the crown court had started to increase before the pandemic because of the government's decision to reduce sitting days.¹³ This caused the backlog to grow by close to a quarter between December 2018 and March 2020 (24.1%). The pandemic worsened things even more dramatically, growing the backlog by a further 48.6% between March 2020 and June 2021. A subsequent decline was reversed by the industrial action among criminal barristers, which pushed the outstanding caseload in the crown court to a record high of 62,844 in September 2022.

Concerningly, progress in reducing the crown court backlog was limited between September 2022 and March 2023, and has since reversed. Even before this, the government was set to miss its target to reduce the backlog to 53,000 by March 2025 by years.¹⁴ Even if the government were to meet this target, the backlog would still be 30% higher than on the eve of the pandemic.

However the backlog is even worse than the headline figure suggests. Because courts struggled to hold jury trials during the pandemic, the composition of the backlog has shifted to include a much higher proportion of cases requiring jury trials. As such, the case mix in the backlog is much more complex than at the start of the pandemic. Accounting for this additional complexity, the backlog in Q2 2023 was equivalent to 89,937 cases, compared to the official figures of 64,709. This means that on the basis of how much work it will take to clear, the current backlog is actually 136.9% larger than at the start of the pandemic.

Figure 8.9 **Case backlog in the crown court, Q2 2010 to Q2 2023**



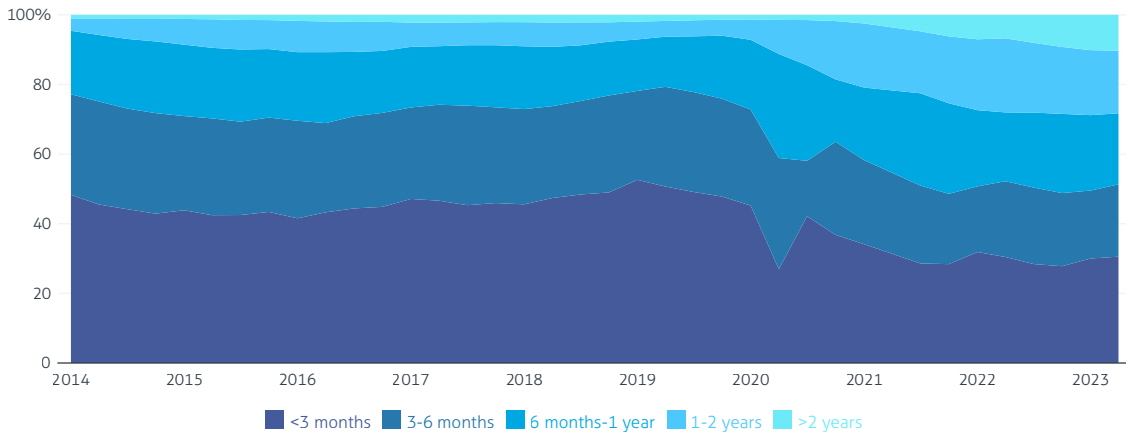
Source: Institute for Government analysis of MoJ, 'Criminal court statistics, April-June 2023' ('Table C1'), supported by CIPFA. Note: Complexity-adjusted backlog is based on IfG modelling and accounts for the greater share of cases awaiting jury trial in the backlog.

Backlogs have contributed to the worst waiting times on record, severely delaying justice

Larger backlogs mean victims and defendants waiting for more time until they can have their cases closed. This is particularly apparent in the crown court. Over the six years before the pandemic, between 40% and 50% of crown court cases were dealt with in less than three months. This proportion declined during the pandemic and reached its worst recorded level in Q4 2022, when only 27.8% of cases were dealt with in that time frame.

The flip side of this is that a greater proportion of cases now take much longer to be processed. Since the start of the pandemic, the proportion of cases taking over a year has increased from 7.2% to 28.3%. In absolute terms, this means there are now over six times as many cases taking more than a year than there were in March 2020.

Figure 8.10 **Waiting times of cases in the crown court backlog, Q1 2014 to Q2 2023**



Source: Institute for Government analysis of MoJ, 'Criminal court statistics, April-June 2023' ('Table O3'), supported by CIPFA. Note: Figures are only available from 2014.

Longer waiting times mean people experience a poorer quality of justice. People's memories fade over time and it becomes increasingly likely that victims (especially of the most serious offences) withdraw from cases.^{15,16} The former victims commissioner attributed this to victims' inability to process trauma, arguing that 'justice delayed is justice denied'.¹⁷ And the longer waiting times have a wider impact on the criminal justice system too, as they mean defendants spend longer in custody awaiting trial – so placing even more pressure on prisons (see the Prisons chapter).

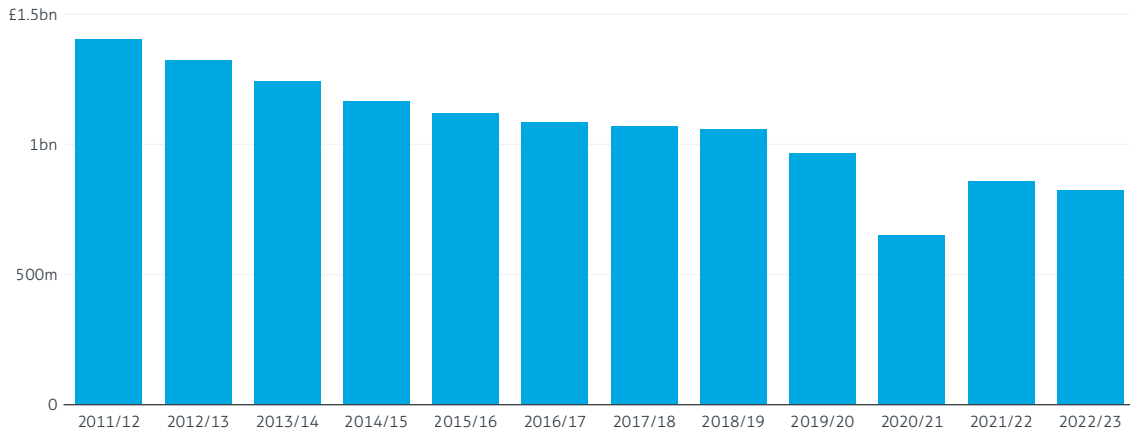
The government must contend with an increasingly dissatisfied workforce

Courts' ability to process cases depends not only on the number of sitting days but also the number of available legal practitioners, including magistrates, judges and barristers, as well as other court staff. This remains a significant problem.

As noted, the criminal courts system was severely disrupted by the barristers' strike, which came to an end in October 2022 after the government extended a 15% rate rise to most criminal cases.¹⁸ Despite this, we have heard that many of the problems facing barristers (including capacity still being too limited and barristers being overstretched) have worsened over the last year.¹⁹ This is consistent with the problems identified in the Bellamy Review of legal aid, which heard that retention of experienced barristers is a significant problem.²⁰ Real-terms spending on criminal legal aid has declined by 43% since 2011/12, which has led barristers and solicitors to increasingly diversify their practice away from criminal work, a trend exacerbated by the pandemic. Overall, there was a 9.8% decline in the number of full-time criminal barristers* between 2017/18 and 2021/22.²¹

* Barristers that self-declared to the Bar Council that at least 80% of their gross fee income in the respective year came from criminal work. This work could be split between public and private criminal work (although they all received some income from public funding).

Figure 8.11 Criminal legal aid spending, 2011/12–2022/23 (2023/24 terms)

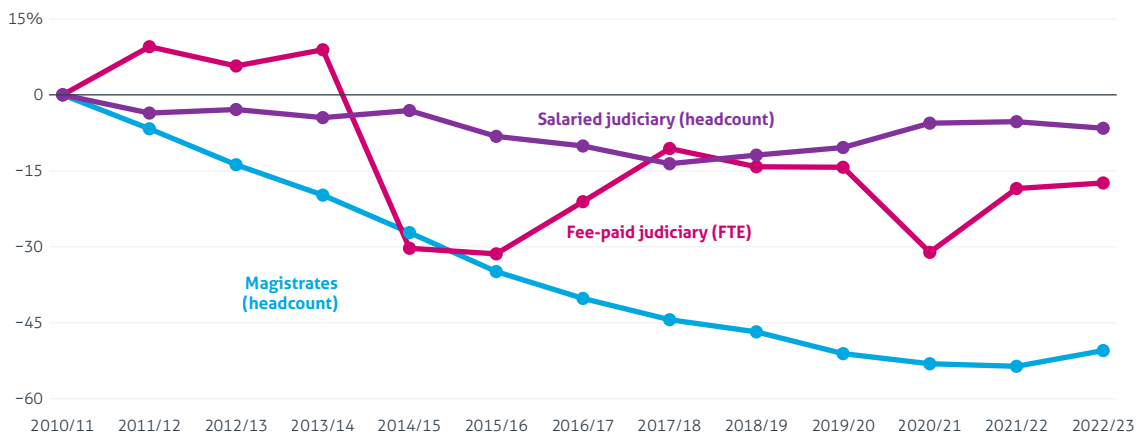


Source: Institute for Government analysis of MoJ, 'Legal aid statistics England and Wales tables Jan to Mar 2023', supported by CIPFA. Notes: Figures are only available from 2011/12. Real-terms spending here is calculated using the consumer price index.

The work of courts has also been impeded by a shortage of other key staff groups. Magistrate numbers have fallen significantly in recent years. In 2021/22, there were fewer than half the number of magistrates than in 2010/11 (down 53.6%) due to recruitment freezes. A national recruitment campaign that aimed to boost magistrate numbers by 4,000 was launched in January 2022, and contributed to an increase of 830 magistrates between 2021/22 and 2022/23, a 7% increase.²² This is the first increase since 2010/11, although magistrate numbers are still over 50% lower.²³

The government has also attempted to increase judicial capacity over the last year, including by allowing certain district and High Court judges to sit in the crown court and by raising the judicial retirement age by five years (which also applies to magistrates).²⁴ Despite this, the number of FTE fee-paid judges only increased by 15 over the last year, while the headcount of salaried judges declined by 13, with both below 2010/11 levels.

Figure 8.12 Change in magistrate and judge numbers since 2010/11



Source: Institute for Government analysis of HMCTS, 'Annual Report and Accounts 2022-23' and MoJ, 'Diversity of the Judiciary: 2023 statistics', supported by CIPFA.

Judicial capacity has still been described by the Lord Chief Justice as an 'acute problem', with shortages of circuit judges* in particular affecting London and the Midland crown court circuit.²⁵ In recent recruitment rounds for circuit and district judges, the Judicial Appointments Commission has been unable to fill more than 84% of advertised vacancies, with one district judge round only filling 67% of vacancies.²⁶

We have also been told by several interviewees that morale is low across the judiciary. This seems to be borne out by survey data published in March 2023, which suggests that 55% of salaried judges' morale is affected by salary issues; this is 4 percentage points higher than 2020.²⁷ Similarly two-thirds of salaried judges claim that working conditions were worse in 2022 than two years previously (compared to one-third for fee-paid judges).²⁸

* Judges that sit in crown and county courts in a given jurisdiction.

9. Prisons



Prisons: key figures

- **£3.7 billion** – the amount spent on prisons in 2021/22. That is 4.3% below 2020/21.
- **88,225** – the size of the prison population in mid-October 2023. An increase of 13.4% on April 2021, and of 6.2% on March 2020.
- **1.3%** – the increase in the number of full-time-equivalent (FTE) operational prison officers between March 2022 and March 2023.
- **50%** – the proportion of prison staff with less than five years' experience. This is more than twice the 2009/10 figure (23%).
- **84%** – the increase in rates of self-harm among female prisoners between March 2022 and March 2023.

Introduction

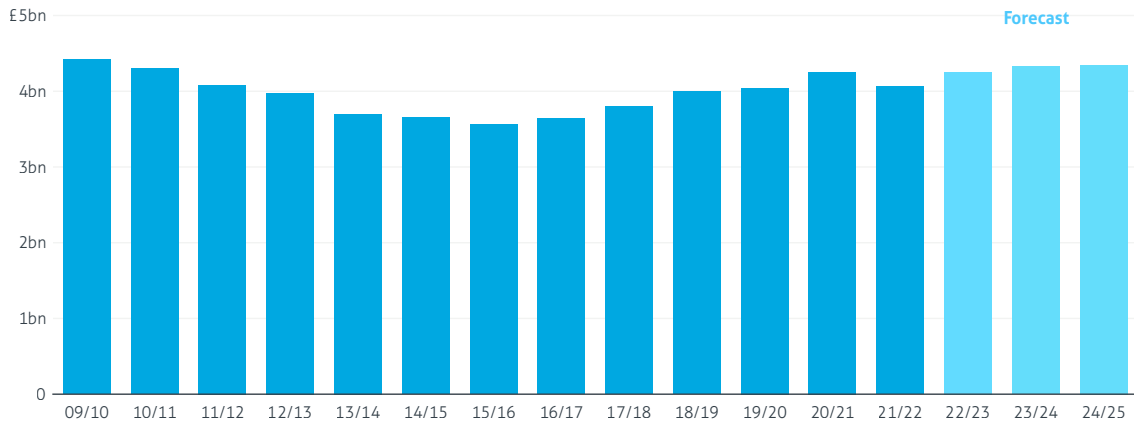
The prison service is in crisis. Since mid-2021, the prison population has been increasing at a rapid rate that is becoming increasingly unsustainable. The population is far above the prison service's level of decent accommodation, and continues to edge closer to the upper limit of what is feasible while maintaining prisoner safety. This comes despite increases in staff over this period and real-terms spending increases from the mid-2010s. And the problem may get worse, with the Ministry of Justice expecting the number of prisoners to increase three times faster than prison capacity, leaving the prison population substantially higher than even prisons' maximum theoretical capacity. Concerns over prisons overflowing have recently led to a series of rapid policy changes, despite the fact that the problems they seek to address have been known about for years.

In the context of a booming prison population, workforce shortages combined with high levels of turnover and inexperience among existing staff are particularly concerning. These workforce problems have contributed to a situation in which, a year after Covid lockdown restrictions were formally lifted, some prisoners remain in their cells for up to 22 hours per day. This places severe limitations on prisoners' access to rehabilitative activities and health services. Similarly, levels of violence, both between inmates and assaults on staff, fell sharply at the start of the pandemic but have since started rising again. And rates of self-harm in female prisons are 119% higher than on the eve of the pandemic.

While recent policy changes may take the pressure off prisons' population growth, the government must find a long-term solution if it is to avoid a cycle of repeat crises. In the absence of such a solution, we can continue to expect dangerous conditions that harm prisoners, prison officers and the wider criminal justice system.

Spending on prisons fell in 2021/22

Figure 9.1 Spending on prisons, 2009/10–2021/22 (2023/24 prices)



Source: Institute for Government analysis of MoJ, 'Costs per prison place and prisoner by individual prison', 2009/10–2021/22, supported by CIPFA. Notes: See Methodology for details of how figures have been put into real terms and for details of how 2022/23–2024/25 spending figures have been estimated.

Following deep cuts in the first half of the 2010s, prisons spending increased from 2015/16. The trend continued in the first year of the pandemic, with spending rising by 5.1% in 2020/21, before falling by 4.3% to £3.7bn in 2021/22 as Covid support measures ended. Following the 2022 autumn statement and current inflation forecasts, spending is expected to increase in real terms by 1.6% in 2023/24, leaving spending 1.7% below 2009/10 levels.

In 2021, the government committed to spending £3.75bn to deliver 20,000 new prison places, including 2,000 temporary units, by the mid-2020s. There is also a need to refurbish the existing estate. The backlog of highest priority major capital works was estimated to be £1.4bn in July 2023.¹ These include projects to address significant health and safety or fire safety risks. The backlog has been increasing (from £900m in 2019/20) by around £225m per year.²

The prison population has grown rapidly in 2023

The prison population fell sharply at the start of 2020, declining by 6% over the year to March 2021. This was the result of pandemic-driven court closures and social distancing, which slowed the number of cases able to progress through the courts, and therefore sentencings, as well as releasing a small number of people early. Between April 2021 and December 2022, the prison population increased at an average rate of 220 people per month. Between December 2022 and mid-October 2023, this increased to 605 per month, helping the total prison population reach 88,225 – the highest level since at least January 2011.

Figure 9.2 **Prison population, January 2011 to October 2023**



Source: Institute for Government analysis of MoJ, 'Prison population statistics', 2011–2023, supported by CIPFA.
Notes: Consistent figures are only available from 2011. At time of publication, monthly October figures were unavailable. Final figure refers to weekly data.

The recent increases are largely due to the progression of court cases previously delayed first by the pandemic and then by barristers' strike between April and October 2022.³ Part of this growth is also attributable to the large number of people on remand (people in custody awaiting trial), which has increased by 54.2% between March 2020 and June 2023.⁴ This is again largely due to the backlog in crown courts.⁵ Interviewees also told us that the trend in defendants receiving longer sentences is contributing to the growing size of the prison population, as well as prison recalls.*

Prisons are full

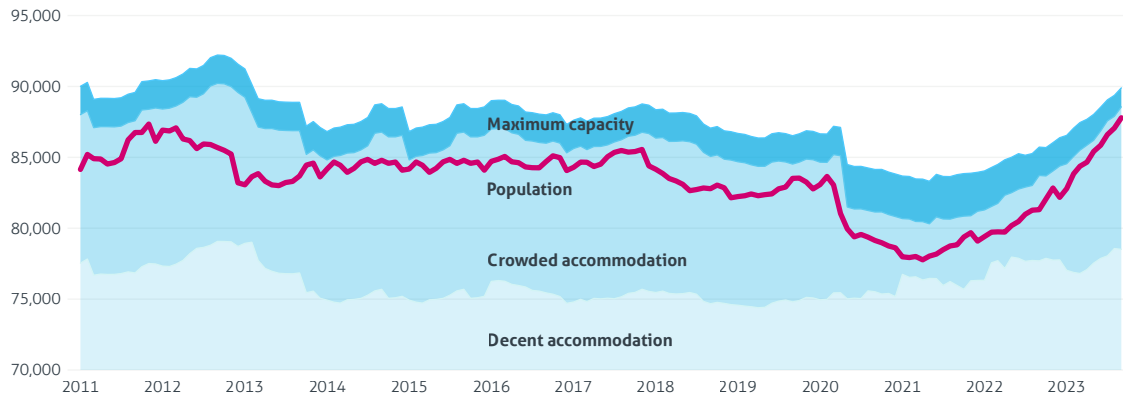
In recent months, the capacity crisis has left the prison system at serious risk of collapse. Each prison reports a total operational capacity – the number of prisoners each can hold while accounting for security and the functioning of the prison regime. The closer the prison population is to operational capacity, the harder it is to maintain security and provide appropriate accommodation. Current demand is stretching prisons' capacity, and makes it necessary to house prisoners in otherwise unsuitable accommodation.⁶ In mid-October 2023, the prison population was 1,897 places shy of total operational capacity – the closest recorded level – compared to 3,624 the previous year.** This has happened despite growth in prison places and staff over this period and an even bigger increase in the reported total operational capacity.

Prisons also publish a certified normal accommodation (CNA) level – the prison service's own measure of how many prisoners can be held in good, decent accommodation. Since 2011, when this data was first published consistently, the prison system as a whole has been operating above its CNA. The increase in the prison population between May 2021 and September 2023 means just 10.6% of prisoners are not being held in accommodation judged 'decent' by the prison service itself, compared to 2.0% at the start of this period.⁷ The Prison Governors Association has previously warned that attempts to increase capacity further within the existing estate (for example, by housing more prisoners in existing cells) would be met with legal action.⁸

* Being returned to prison if the rules of probation are broken.

** Based on monthly data releases

Figure 9.3 **Prison population and capacity, 2011–2023**



Source: Institute for Government analysis of MoJ, 'Prison population figures', 2011–2023, supported by CIPFA.
 Notes: Figures are only available from 2011. Data is from monthly releases. 'Decent accommodation' is the 'in-use CNA' (certified normal accommodation), which represents the 'decent standard of accommodation that the Service aspires to provide', above which prisoners are accommodated through crowding. 'Maximum capacity': the lower bound represents the upper limit of prison capacity minus the margin needed to provide accommodation for different classes of prisoner.

While there is considerable uncertainty over the speed at which the crown court backlog will be cleared, the impact of the extra police officers and sentencing policy, the Ministry of Justice's (MoJ) central projection is that the prison population will grow to 94,400 by March 2025, some 7,800 more than in July 2023.⁹ However, the government expects to be able to build only around 2,600 places between July 2023 and June 2025.¹⁰ Despite pledging to build 20,000 places by the mid-2020s, these places are instead more likely to be delivered by the end of the decade.¹¹ That would mean the number of prisoners growing around three times faster than the prison estate's capacity to accommodate them, leaving the prison population substantially higher than even the maximum theoretical capacity of prisons. This maximum capacity itself comprises a number of Victorian-era prisons, which, according to HM Inspectorate of Prisons (HMIP), would ideally be shut down.¹²

Several attempts have been made to try to control the size of the prison population. Most recently, the government has been forced to announce policy changes to allow for early releases for some lower level offenders, and will legislate to suspend some shorter sentences.¹³ Occasioned by the acknowledgement that prisons were dangerously close to full, these measures will likely increase short-term capacity. However, they are only the latest in a string of attempts to stem the population.

Controversially, the government has previously advised judges to consider prison capacity when sentencing.¹⁴ Similarly, magistrates' sentencing powers were halved (having been increased from six to 12 months less than a year prior) due to limited prison space.¹⁵ Non-essential prison maintenance has been postponed so as not to diminish prison capacity in the short term, though this could store up problems for the future. An agreement was also reached with the National Police Chiefs' Council ('Operation Safeguard') to allow the government to temporarily use up to 400 police

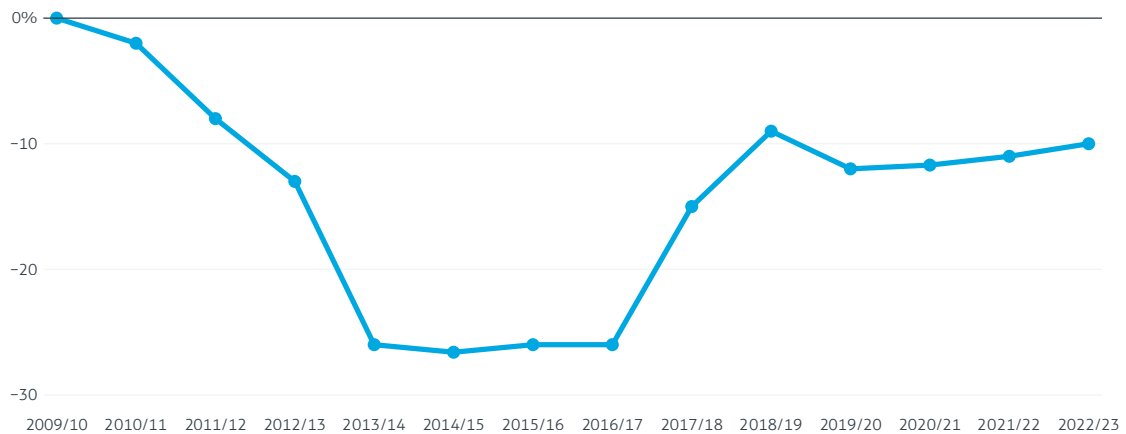
* One problem the government has faced in delivering on its pledge of 20,000 extra places is gaining planning permission for several new prisons, <https://insidetime.org/exclusive-new-prisons-cant-open-before-2027-prison-service-official-admits>

cells to provide extra short-term capacity.¹⁶ This has been criticised by HMIP for failing to cater for the often complex needs of prisoners.¹⁷ While the most recent changes may increase capacity, they are not necessarily the long-term fixes that the government will have to find to avoid a cycle of prison population crises.

The number of prison officers grew in the past year, but retention is still poor

The overall number of operational prison officers increased by 1.3% in 2022/23, though this still leaves total staff levels 10% below 2009/10.* This means the number of prisoners per operational staff member has increased to 3.8 in June 2023, from an estimated 3.5 in June 2010.

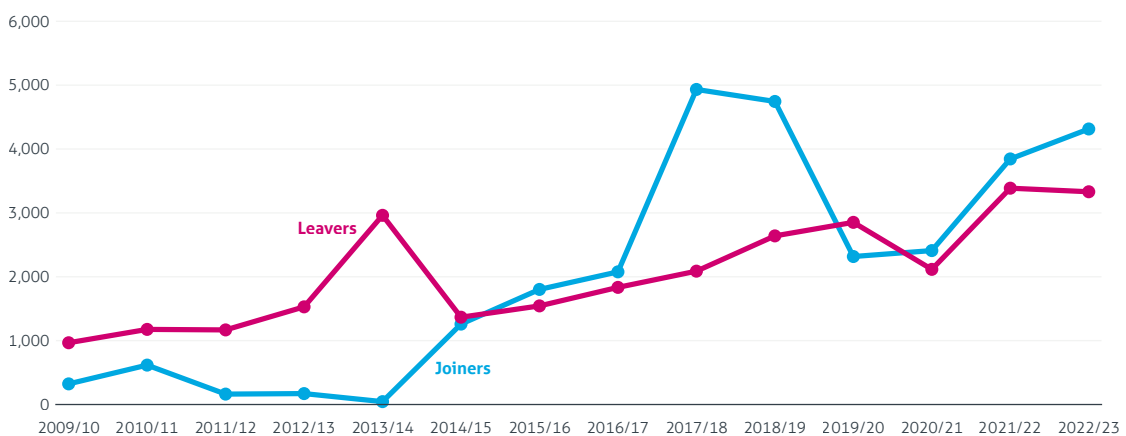
Figure 9.4 Change in prison officer numbers (bands 3–5) since 2009/10



Source: Institute for Government analysis of HMPPS, 'Workforce statistics bulletin' ('Table 3'), 2009/10–2021/23, supported by CIPFA.

The number of joiners increased 12% over the year, to 4,314, while the number of leavers decreased slightly by 1.7%, to 3,331. This is a slight improvement on the number of leavers from last year, but attrition is still high – with 15% of the total band 3–5 operational workforce leaving the prison service in 2022/23.

Figure 9.5 Prison officer joiners and leavers (bands 3–5), 2009/10–2022/23

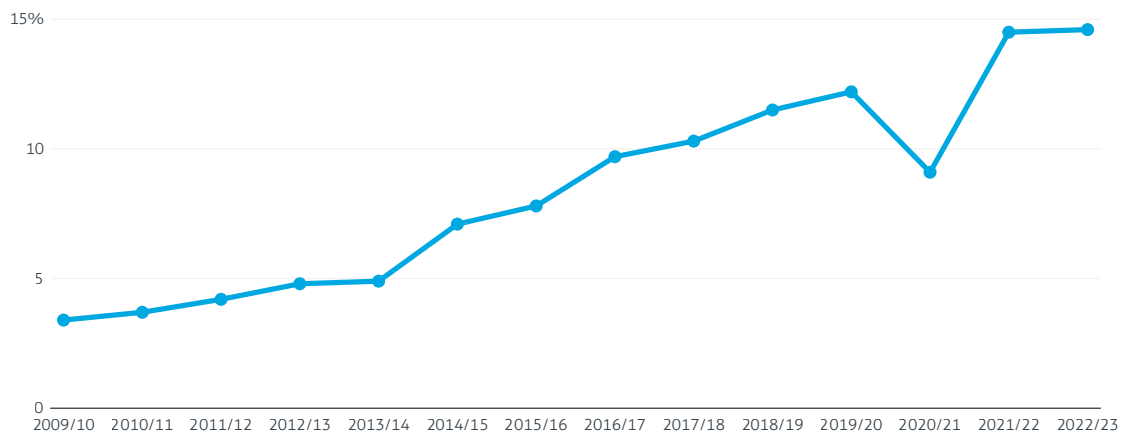


Source: Institute for Government analysis of HMPPS, 'Workforce statistics bulletin' ('Table 8'), 2009/10–2021/23, supported by CIPFA.

* This refers to bands 3–5 operational staff (front-line officers, supervisors and managers).

Indeed, barring a pandemic-induced fall in 2020/21, the leaving rate has increased every year since at least 2009/10, when it was just 3.4%. Resignation is the biggest driver, accounting for two thirds (66.8%) of all leavers in 2022/23.¹⁸ Dismissals due to conduct or poor attendance are another big driver. One interviewee told us that the high dismissal rate was due in part to unsuitable candidates passing poor vetting processes. They also blamed insufficient support for inexperienced staff, leaving them ill equipped to manage the ballooning prison population.

Figure 9.6 **Prison officer leaving rate (bands 3–5), 2009/10–2022/23**



Source: Institute for Government analysis of HMPPS, 'Workforce statistics bulletin' ('Table 11'), 2009/10–2021/23, supported by CIPFA.

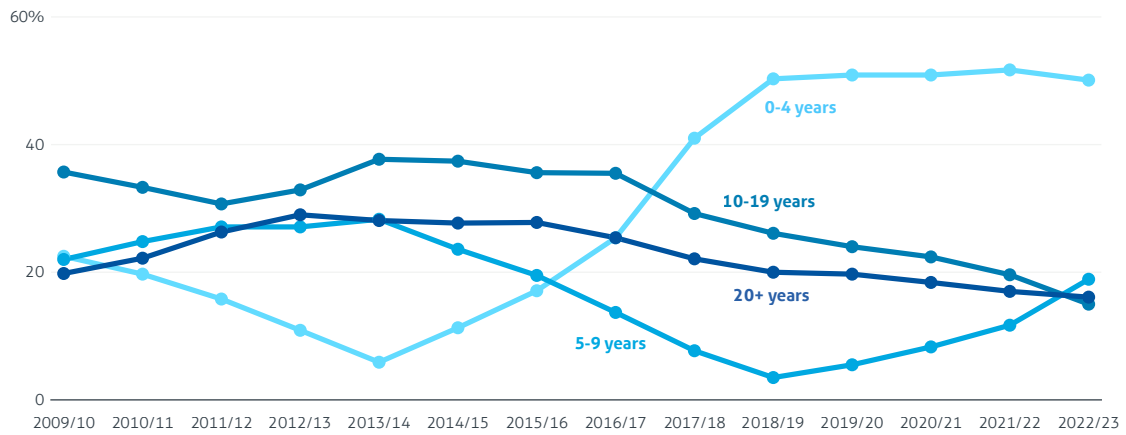
The MoJ has argued that, along with leadership and career progression, health and wellbeing is another key driver of staff attrition.¹⁹ Furthermore, prisons face competition from services like the Border Force, police and private sector employers, who often offer safer conditions, better financial incentives and more flexible working arrangements.²⁰

Many staff are inexperienced and sickness absence remains high

Prison capacity is a function not just of physical space but also of having enough staff with the right experience to make best use of that space. The loss of experienced officers can harm the quality of support and supervision prisoners receive, as newer staff are both less able both to cope with difficult situations and to build long-term relationships with prisoners.

Deep staff cuts from 2010 onwards meant the prison service lost many experienced staff, leaving new officers learning from a much less experienced workforce.²¹ Indeed, the workforce has become increasingly inexperienced over the last decade. The proportion of officers with more than 10 years' experience has nearly halved in recent years, from 61% in 2016/17 to 31% in 2022/23.

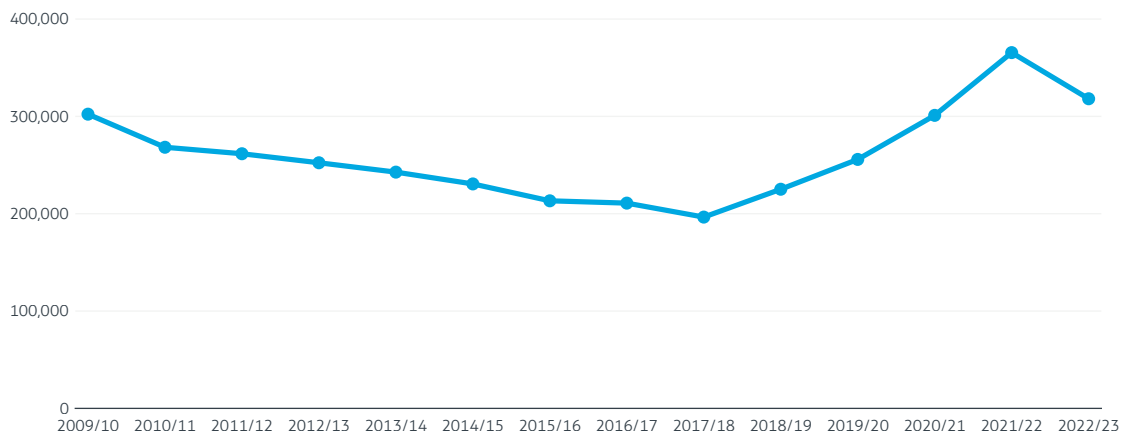
Figure 9.7 Prison officer experience (bands 3–5), 2009/10–2022/23



Source: Institute for Government analysis of HMPPS, 'Workforce statistics bulletin' ('Table 4'), 2009/10–2021/23, supported by CIPFA.

There has been an improvement over the past year in the availability of staff, with the number of sick days declining 13% in 2022/23 (driven by a 42% decline in days lost due to epidemic/pandemic over this period). However, the number of days lost to sickness is still 24% higher than in 2019/20.

Figure 9.8 Prison officer sick days (bands 3–5), 2009/10–2022/23



Source: Institute for Government analysis of HMPPS, 'Workforce statistics bulletin', Table 20, 2009/10–2021/23, supported by CIPFA.

Staffing problems mean prisons are still unable to safely unlock prisoners

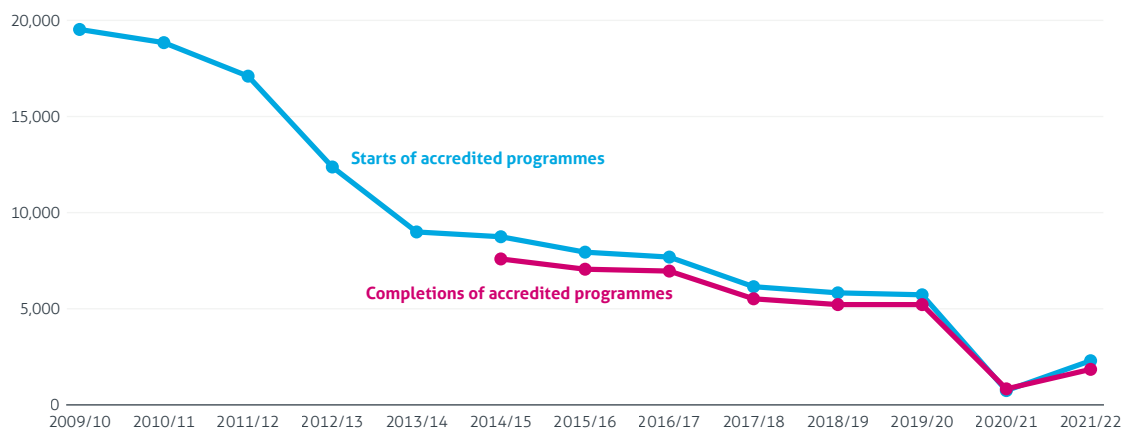
Even though Covid restrictions in prisons were formally lifted in mid-2022, the HMIP found in July 2023 that many prisoners were spending considerably less time out of their cells than had been the case before the pandemic.²²

Among prisoners surveyed across 2022/23, some 42% of men spent less than two hours out of their cells during weekdays, rising to 60% during the weekends. For women's prisons the figures were 36% and 66% respectively.²³ Inadequate staffing levels may also prevent prisons being able to accommodate new prisoners even when refurbished cells are ready to be used.²⁴

Workforce shortages and staff inexperience at a time of over-populated prisons explains much of this.^{25,26} Many staff have no experience of pre-pandemic regimes and simply do not feel confident allowing prisoners out of their cells to a healthy extent; HMIP has also argued that the rises in prison violence in the last decade (discussed below) also explains this reticence.²⁷ Many prison officers who saw violence rates plummet during the lockdowns may believe that is the only way to control violence. When prisoners do leave their cells, staff are similarly less able to manage violent behaviour.²⁸

Staffing problems limit access to rehabilitative activities

Figure 9.9 **Starts of and completions of accredited programmes, 2009/10–2021/22**



Source: Institute for Government of MoJ, 'HMPPS Offender Equalities Annual Report 2021 to 2022' ('Chapter 5 tables: Accredited programmes in custody'), supported by CIPFA.

Keeping prisoners locked up or in overcrowded conditions limits their access to critical services. Dominic Raab, when justice secretary, wrote in February 2023 that “operating close to capacity” will result in “reduced access to rehabilitative programmes”.²⁹ Similarly, HMIP has sounded the alarm over the potential for overcrowding to hinder purposeful activities.³⁰ Ofsted has also argued that limited access to, for example, individual learning plans linked to prisoners’ sentences may result in missed opportunities to reduce reoffending rates and successfully rehabilitate prisoners.³¹

Shortages of prison officers have been compounded by difficulties recruiting and retaining prison educators. Comparatively poor pay, unsafe conditions and the lack of career development opportunities inside prisons has contributed to hundreds of vacancies and increased use of agency staff to provide prison education.³²

Over the past year, there has been an increase in the number of starts on accredited programmes – interventions offered to offenders with the aim of reducing reoffending³³ – following the near cessation of these during the first year of the pandemic. However, due to overcrowding and staff shortages, there are still far fewer prisoners undertaking training and education in prisons than before Covid. Indeed, the Justice Committee found that 84% of band 3–5 staff believe staff shortages prevent prisoners engaging in purposeful activities.³⁴ Starts of accredited programmes in

2021/22 were 60% below 2019/20 levels, and 88% below 2009/10 levels. Indeed, a recent report on HMP Risley found no accredited programmes were being offered to the 40% of the prison population serving sentences for sexual offences.³⁵ Similarly, Ofsted has noted the poor overall quality of education provision in men’s prisons, 60% of which are rated as ‘inadequate’.³⁶

Inexperienced staff provide less effective care to prisoners

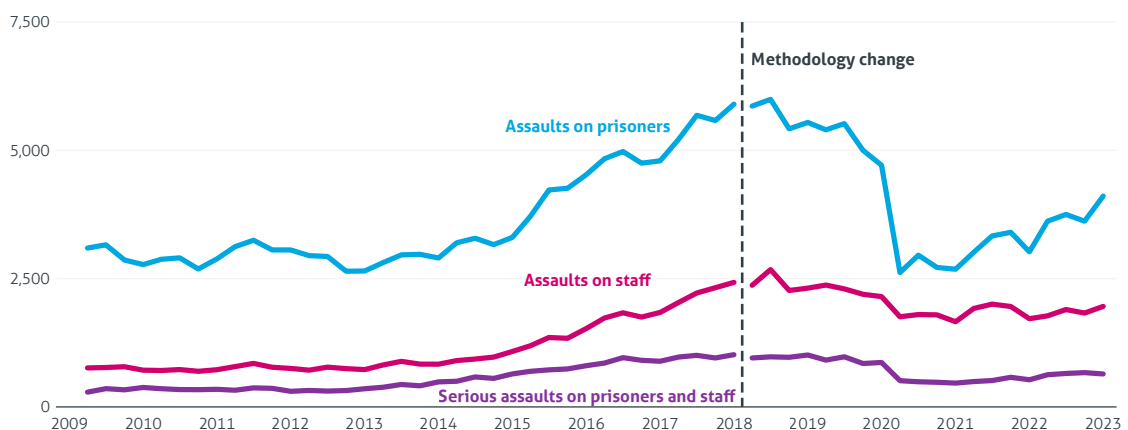
Health care in prisons is poor. With prisons struggling to operate more than basic regimes, it is difficult to train staff to adequately cope with prisoners’ health needs (particularly mental health). Indeed, a recent analysis of Independent Monitoring Boards reports have highlighted the impact of the staffing crisis on prisoner health, with increasing reliance on agency staff, shortages in clinicians and chaperones, and inadequate suicide and self-harm training contributing to declines in both mental and physical health support.³⁷

Interviewees told us that inexperienced staff are less adept at helping prisoners in need of special care. This is concerning given the worse state of health among prisoners than in the general population. The Nuffield Trust has reported that this disparity is particularly acute in those aged over 50 who, for example, suffer higher rates of frailty than in the general population. The over-50 cohort has grown by 6.7% between March 2022 and March 2023, compared to growth of 5.6% in the number aged under 50.³⁸

This loss of experienced staff may also contribute to the number of deaths in prison. One report found that prison staff’s lack of understanding of procedures for monitoring suicide and failures of communication between prison and health staff are common concerns among inquests and coroners’ reports relating to deaths in prisons.³⁹

Violence decreased dramatically at the start of the pandemic, but has steadily increased since

Figure 9.10 Prison assaults, Q2 2009 to Q1 2023



Source: Institute for Government analysis of MoJ, ‘Safety in custody statistics’ (‘Table 7’), Q2 2009 to Q1 2023, supported by CIPFA. Notes: Figures from Q2 2018 onwards exclude incidents occurring within the youth estate.

Incidents of assaults on staff and prisoners grew dramatically – the latter doubling – between 2012/13 and 2017/18, before starting to fall in 2018. This has been attributed to a declining prison population in that period, along with greater investment in staff, and policies like the Challenge, Support and Intervention Plan for managing violent offenders.⁴⁰ This initial decline was accelerated during the pandemic, as prisoners were physically unable to spend as much time together during lockdowns.⁴¹ However, between Q2 2020 and Q1 2023 the number of prisoner-on-prisoner assaults grew by 56.9%. Overall, there was a 31.5% increase in the total number of assaults per 1,000 prisoners in men’s prisons, and a 81.9% increase in women’s prisons.

Similarly, a decline starting in 2018 of assaults on staff was accelerated by the onset of the pandemic. Since then, assaults on staff have remained broadly flat, but are still higher than at any point before 2015/16 (although the headline figures obscure variations in the performance of individual prisons).

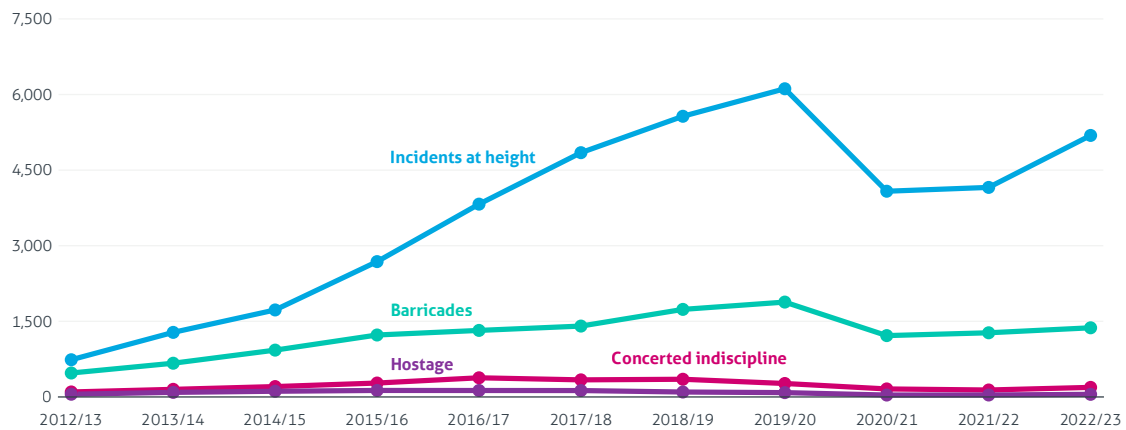
The recent rise in assaults on prisoners has been attributed to the easing of lockdown restrictions in some prisons, and particularly to the frustration among prisoners at being locked up for so long,⁴² compounded by the inexperience of many staff.⁴³

Similar reasons are likely driving incidents of ‘protesting behaviour’, which are categorised as follows:

- **Barricades:** using barriers to deny access to all or parts of a prison
- **Hostage incidents:** holding people against their will
- **Concerted indiscipline:** two or more prisoners not complying with instructions
- **Incidents at height:** incidents taking place above or below ground level.

Incidents of all four categories increased in 2022/23, following falls in incidents at height and barricade incidents at the onset of the pandemic, and longer term declines in hostage and concerted indiscipline incidents. While hostage taking is still less prevalent than in 2012/13 (the earliest year for which data on all types of protest behaviour is available), the other three are much more common, with nearly twice as much concerted indiscipline, nearly three times as many barricade incidents in 2022/23, and seven times as many incidents at height.

Figure 9.11 Change in prison protests since 2012/13



Source: Institute for Government analysis of MoJ, 'HMPPS Annual Digest, April 2022 to March 2023' ('Chapter 7 Tables – Protesting behaviour'), supported by CIPFA. Notes: Figures are only available from 2012/13.

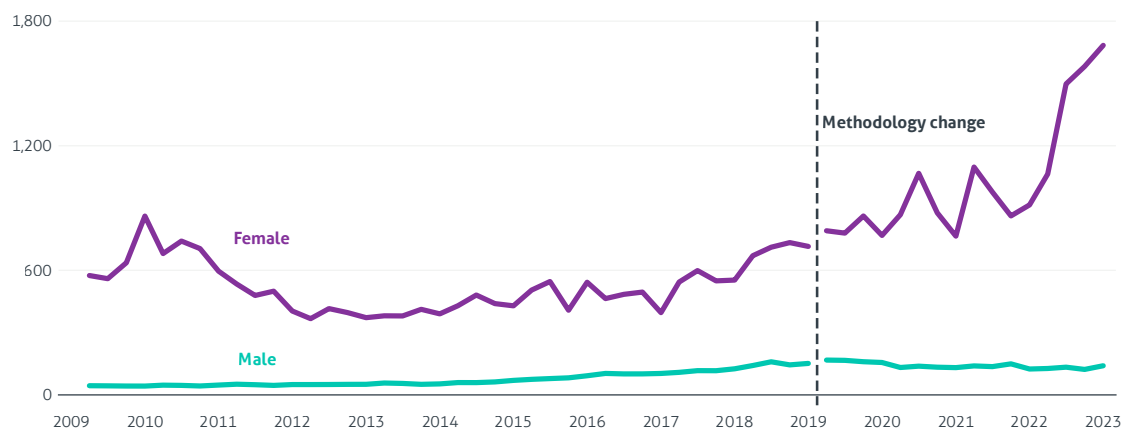
Prisons urgently need to address these trends. However, we have heard that efforts to do so – as well as efforts to design and implement new post-pandemic prison regimes – are being significantly disrupted by the pressures of housing a rapidly expanding population.

Rates of self-harm are at record levels in women's prisons

Incidents of self-harm are markedly different between men's and women's prisons, with rates far higher in the latter. In Q1 2023 alone, there were 1,683 incidents of self-harm per 1,000 female prisoners, equating to 5,469 incidents overall. This compares to 140 incidents of self-harm per 1,000 male prisoners, and 11,074 incidents overall.

Between 2012/13 and 2019/20, rates of self-harm per prisoner grew by 61.0% in women's prisons and 51.7% in men's prisons. However, the trends diverged after the onset of the pandemic. In women's prisons, the rate increased by a further 79% between 2019/20 and 2022/23, and HMIP has warned that prison officers and staff are inadequately trained to care for women with more complex health needs.⁴⁴ In contrast, incidents of self-harm per male prisoner fell by 8% over the same period.

Figure 9.12 Self-harm rates per 1,000 prisoners, Q2 2009 to Q1 2023



Source: Institute for Government analysis of MoJ, 'Safety in Custody summary tables to March 2023' ('Table 6 Quarterly self-harm'), supported by CIPFA. Notes: Figures from Q2 2019 onwards exclude incidents occurring within the youth estate.

10. Methodology



10. Methodology

0. Cross-service analysis

Public services spending, including estimates of the total spend on public services

To estimate the real cost of public spending, we deflate government spending figures using the GDP deflators published by the Office for Budget Responsibility in the *Economic and Fiscal Outlook* from March 2023.¹ To better reflect the underlying inflation conditions present in 2020/21, we estimate our own figures by generating a mid-point that averages across values from 2019/20 and 2021/22. We deflate spending figures in our financial analysis across all *Performance Tracker* chapters to 2023/24 prices.

In cases where we calculate real-terms changes in figures that relate to individuals – for example, wages or the adult social care means test – we use the consumer price index rather than the GDP deflator. The CPI that we use also comes from the OBR’s *Economic and Fiscal Outlook* from March 2023.

Change in demand for public services

General practice

To project likely growth in demand for general practice, we use analysis from The Health Foundation. Its main published analysis for ongoing demand, published in October 2021,² includes an estimate for how much primary care activity will need to increase to maintain standards, factoring in growing case complexity due to co-morbidities. General practice excludes some services that are included in The Health Foundation’s measure of primary care but includes others (such as drugs dispensed in general practice) that it excludes. But we nonetheless assume that demand for general practice services changes in the same way as demand for primary care.

To ensure comparability with the demand projections shown for other services (for which we do not include service-specific cost pressures or possible productivity gains), we only factor in increases in activity, rather than additional assumptions around changes to pay and productivity.

Hospitals

To project likely growth in demand in hospitals, we again draw on analysis from The Health Foundation. Its analysis provides an estimate of the rate of growth in activity, adjusted for morbidity, needed to meet growing demand for acute care, while maintaining its scope and quality. We assume that demand for acute and specialist trusts (our focus in this chapter) changes in the same way as The Health Foundation’s projection of demand for acute care.

To ensure comparability with the demand projections we show for other services – where we do not include service-specific cost pressures or possible productivity gains – we only factor in increases in activity.

The Health Foundation kindly provided us with a breakdown of its model to allow us to derive an overall estimate of acute care, based on a weighted average of elective, non-elective, A&E and outpatient activities.

Adult social care

For adult social care, we take the projected increase in demand from The Health Foundation's REAL Centre, published in October 2021. This model incorporates several factors, including increases in pay and projected changes in productivity. We take only the increase in activity projected in the model, as the outlook for pay has changed since it was published.

In other services, we only factor in increases in demand, without incorporating above-inflation cost pressures. This is because, for most services, we expect wages to broadly increase in line with economy-wide inflation (the GDP deflator, which will increase less quickly than consumer price inflation), which our spending projections already account for. But this is not the case for adult social care, where a substantial proportion of the workforce is paid the national living wage (NLW), which is set to increase much more quickly than economy-wide inflation. The impact of the NLW is explored in more detail in the adult social care section of this Methodology, below.

Children's social care

To project demand for children's social care, we break down children's social care spending into three service categories based on the data returns that local authorities make to the DfE under Section 251 of the Apprenticeships, Skills, Children and Learning Act 2009.³ For each category, we make the assumptions about rates of growth set out in Table 10.1.

Table 10.1 **Projected growth rates for children's social care**

Service category	Gross spending 2021/22 (£bn)	Growth rate assumption	Projected growth 2019/20 to 2024/25
Foster placements	£1.9bn	Increases in line with the growth in the rate of foster placements per child between 2007/08 and 2021/22	9.3%
Residential care	£2.1bn	Increases in line with the growth in the rate of residential care placements for children in England between 2007/08 and 2021/22	24.5%
Other expenditure	£6.6bn	Increases in line with the rate of episodes of need per child in England between 2012/13 and 2021/22	0%

As 2020/21 was an unusual year due to the pandemic, we project demand from 2019/20 onwards. In common with the assumptions made for other service areas, to project demand growth we assume that the service remains as efficient as it was in 2019/20 and that the cost of providing each service grows in line with economy-wide inflation. If there are cost pressures beyond the projected increases in demand described above, then spending would have to rise faster.

Schools

To project how much schools would have to spend to meet increased demand, we separate primary and secondary schools because:

- on average, the government spends slightly more on each secondary school pupil than on each primary school pupil
- the DfE projects that the number of primary school pupils will fall over the period 2019/20–2024/25 while the number of secondary school pupils will increase.

As 2020/21 was an unusual year, we base our projections on spending in 2019/20 (see Table 10.3). We multiply the 2019/20 level of spending per pupil in primary and secondary schools by expected growth in pupil numbers between 2019/20 and 2024/25 and add together the implied figures for spending on primary and secondary schools. We assume that the costs of the inputs used in providing school services rise in line with economy-wide inflation.

Table 10.3 **Projected growth rates for schools**

Service category	Gross spending 2019/20 (£bn)	Growth rate assumption	Projected growth 2019/20 to 2024/25
Primary schools	£19.8bn	The number of pupils grows in line with DfE projections for the number of primary school children	-6.3%
Secondary schools	£18.5bn	The number of pupils grows in line with DfE projections for the number of secondary school children	7.5%

Criminal courts

We project demand for the crown and magistrates' courts separately.

For the crown court, we calculate demand as the number of cases received each year, weighted by the average hearing time for cases completed in each year. We do this separately for cases that are 'for trial' and other cases (such as appeals and sentencing). We assume that: (i) longer hearing times are a result of cases being more complex, rather than the court operating inefficiently; and (ii) the cases received would have had similar hearing times to the ones disposed of, within case type (cases for trial and others), in the year in question.

For magistrates' courts, where the data we have is less detailed, we measure demand simply as the number of cases received each year.

We weight magistrates' and crown court demand to come to an overall measure of court demand. We do this using two components. First, we use the number of sitting days in the crown court and magistrates' courts in 2018.⁴ Second, we use the average costs per sitting day in the crown court and magistrates' courts, which the National Audit Office reported in 2016, as these are the latest available figures.⁵ This implies that 61% of court demand comes from the crown court and around 39% comes from the magistrates' courts. We then project demand forward separately for the crown and magistrates' courts.

The main driver of our projection of court demand is the increase in police officers; the government met its commitment to increase officer numbers by 20,000 on top of 2018/19 figures by April 2023.⁶ We assume that an increase in the number of officers means the police can charge more cases, because as it stands the number of charges is only a small fraction of total crimes reported. The number of charges per police officer has fallen steadily for several years, in part due to underfunding elsewhere in the criminal justice system.

We assume that once officers are embedded the number of charges per officer will return to and stay at 2019/20 levels. However, we assume that there is a lag of three years between recruitment and a return to 2019/20 levels of charges, as this is the time it has taken between the start of the uplift programme and an increase in that indicator. We therefore project that charges per officer will return to 2019/20 levels in 2026/27, increasing uniformly between 2022/23 and 2026/27.

In the magistrates' courts, we assume that the least serious 'summary' cases are unaffected by the number of police officer charges as some of these are brought by non-police organisations and they are simple, routine offences. With all other cases, in both the crown and magistrates' courts, increases occur in line with the lag described above.

Prisons

To project demand for prisons, we use the Ministry of Justice's (MoJ) central estimate for prisoner numbers over the five years from 2022 to 2027, which was published in February 2023.⁷

The MoJ's central estimate is that the prisoner population will rise by 13.5% between March 2020 and March 2025 (and by 20.9% between March 2021 and March 2025). This projection incorporates the recruitment of the additional 20,000 police officers and the estimated impact of other policies, including: the provisions for increasing the release point for violent and sexual offenders sentenced to a standard determinate sentence of four to seven years; the statutory instrument to increase custodial sentences for serious offenders with a custodial sentence of seven years or more; the Serious Crime Act 2015; the Offensive Weapons Act 2019; and the Domestic Abuse Bill 2020.

Average criminal justice system timeliness in days (Figure 0.1)

Figures reported in this chart are median figures and refer to calendar years. This is also true of the total 'offence to completion' measure. As such, the individual 'offence to charge', 'charge to first listing' and 'first listing to completion' may not sum to the total 'offence to completion' figures.

'Offence to charge', 'Charge to first listing' and 'First listing to completion dates' waiting times (in days) are taken from the MoJ's quarterly criminal courts dataset.⁸

Capital spending index, public service departments, 2004/05–2022/23 (Figure 0.3)

The primary problem in the creation of this chart is change in departmental structures and responsibilities. To circumvent this issue, we create a retrospective time series, using the most recent outturn as the baseline for the years 2018/19 to 2024/25 (the years for which there is data in the PESA tables).⁹ We then input the PESA results for previous years. We transform the last outturn year (2018/19) by the change in spending for the previous PESA outturn. We then replicate this method for all departments and for all years going back to 2004/05.

Average annual real-terms change in planned capital spending at successive multi-year spending reviews (Figure 0.4)

We deflate the capital department expenditure limit (CDEL) at each multi-year spending review by the most recent GDP deflator at the point when the spending review was published, for each department. We then calculate the average annual increase in real-terms CDEL. To account for changes in departmental responsibilities, we combined police and justice CDEL to make spending reviews comparable between 2002 and 2021.

Change in median gross earnings of selected public sector professionals since 2009/10 (Figure 0.7)

The ONS has changed how it classified professions twice since 2009/10. To ensure consistency we cross-referenced codes against volumes of employees to check similar numbers of staff were being assessed. The most affected data series was nursing professionals, for which we used data for health associate professionals for 2009/10, nursing and midwifery professionals for 2010/11–2019/20 and nursing professionals for 2020/21–2021/22. Additionally, figures for primary education teaching professionals include nursery staff up to 2020/21.

Unlike other data series in the report, which were deflated using a smoothed GDP deflator, figures were deflated using the consumer price index as published by the OBR.

Working days lost to strike action in the public sector over the previous 12 months (Figure 0.8)

To calculate the line in this chart, we sum the total number of days lost to industrial action in the public sector in the previous 12 months of any given day.

Average annual real-terms change in spending between 2021/22 and 2024/25 relative to demand under different inflation scenarios (Figure 0.10)

For the nine services we cover in this report, we project how much money the public sector would have to spend to meet demand. To estimate the cost of doing this, we project growth in underlying demand for each service as described above.

For each service we also project how spending is likely to evolve over the course of the spending review (up to 2024/25). The 2021 spending review did not provide budgets for particular public services, only government departments (with the exception of schools and the NHS, which have their own budget lines). For each service, we take the most relevant department's settlement, implicitly assuming that all spending within those budgets will increase at the same rate.

This means that we assume that spending on hospitals will increase in line with NHS spending, spending on courts and prisons will increase in line with MoJ spending, spending on the police will increase in line with Home Office spending, and schools' spending will increase in line with the specific school funding line in the spending review. For the three local government services (adult social care, children's social care and neighbourhood services), we take the government's projections for local authority spending power, which incorporate changes to grants and assumed increases in local taxes (council tax and business rates). For GPs, we assume that spending will increase in line with the amounts laid out in the 2019/20–2023/24 GP contract; for 2024/25, we assume that spending on GPs increase in line with the average change in the GP contract between 2021/22 and 2023/24. We also adjust these spending amounts for recent government announcements. For example, we include the extra £515m that the Home Office announced it would provide to police in 2024/25 to pay for the recently agreed pay deal.¹⁰

To compare the generosity of the cash-terms settlements set out in the 2021 spending review over time, we deflate these numbers using three iterations of the GDP deflator, a measure of economy-wide inflation that is widely used – including by the government – to assess the real-terms generosity of public service spending plans. We take the GDP deflator from the October 2021 spending review itself, the GDP deflator at the autumn statement in November 2022, and the GDP deflator from the March 2023 spring budget, all three from the OBR.

To capture demands on local authorities as a whole, we combine the increases in demand for neighbourhood services, children's social care and adult social care, weighting the projected increases by the 2022/23 spending on each service.

Average annual real-terms change in spending planned at successive multi-year spending reviews (Figure 0.11)

We replicated the methodology that we used for CDEL in Figure 0.4 for resource departmental expenditure limit (RDEL).

Average annual real-terms change in spending between 2024/25 and 2027/28 under current government plans relative to demand (Figure 0.12).

We first increased total RDEL across government by 1% in real terms for each year between 2024/25 and 2027/28. From that we subtracted protected spending.

Protected spending is spending on health, defence and foreign aid. To calculate health spending, we increased spending for the NHS (in this case, general practice and hospitals) by 3.6% in real terms for each year of this future spending review as this is the amount that the Institute for Fiscal Studies (IFS) estimates that it would require to meet the commitments laid out in the *NHS Long Term Workforce Plan*.¹¹ For defence and foreign aid, we increased the budgets of the Ministry of Defence (MoD) and the Foreign, Commonwealth and Development Office (FCDO) by the real-terms GDP forecast from annex A of the OBR's March 2023 *Economic and Fiscal Outlook*. We subtracted these totals from the total RDEL increases previously calculated to work out how unprotected RDEL would change.

We assumed that all unprotected departments would change in line with the change in unprotected RDEL. From there, we offset the spending increases by demand for each service as has already been described in the methodology of Figure 0.10.

1. General practice Change in GP pay (Figure 1.2)

Forecast increases in salaried GPs pay in 2022/23 and 2023/24 is based on pay settlements for those years. It is not possible to make the same calculation for GP partners. Their pay is variable from year to year because they take pay as drawings from GP funding after other expenses have been incurred.

Size of job groups within the primary care workforce (FTE) (Figure 1.5)

The number of GPs used in this chart is the 'All qualified permanent GPs (excludes GPs in training grades and locums)' line from the GP Workforce bulletin tables.

GPs leaving the NHS, by age group (Figure 1.8)

The 'GP workforce – joiners and leavers' dataset gives leaver rates and total leaver numbers for GPs under 30 and then in five-year age bands until 70, at which point all GPs older than that are grouped together. To calculate wider age bands, we calculated the implicit number of GPs in each age band (total leavers/leaver rate), then summed the leavers in those bands and divided that by the sum of the implied number of GPs in that band.

Appointments in general practice (Figure 1.14)

The NHS changed how it collects information on the number and type of appointments in primary care in October 2018. There is an overall time series going back to November 2017, but granular daily counts of appointments are only available from December 2018.

Appointments delivered per FTE (Figure 1.15)

This uses data from the 'Appointments in general practice' dataset and the GP Workforce bulletin. It takes the number of appointments delivered by each staff group for a particular month and divides them by the number of staff members in that staff group in that month. To come to the rolling average, we take the average number of appointments conducted per month in the previous 12 months and the average number of staff in each staff group in that time. For this chart we use the number of fully qualified permanent GPs as the denominator for GP efficiency. 'Other practice staff' is the sum of 'All DPC staff' and 'All nurses'. All calculations are done on an FTE basis.

Specific and acute referrals as a proportion of GP appointments (Figure 1.17)

We calculate this by dividing the number of specific and acute GP referrals in a given month by the number of attended GP appointments carried out in that month. Before July 2021, the 'Appointments in general practice' dataset provided information on the number of attended GP appointments. This stopped from July 2021 onwards. Instead, to calculate the number of attended GP appointments, we take the total number of attended appointments across all of general practice in a given month (as outlined in the 'Appointments in general practice' dataset) and multiply that by the percentage of appointments that GPs carried out (using the SDS Role Group categorisation, rather than HCP categorisation). This step requires us to assume that the attendance rate of GP appointments is the same as the attendance rate of all primary care appointments, an assumption that is unlikely to be met in any month but which will be close enough to make this analysis meaningful. For the monthly number of referrals, we use the 'GP referrals made (specific acute)' data from the 'Monthly referral return' dataset.⁴²

Change in GP numbers and registered patients (Figure 1.19)

As with Figure 1.5, the change in the number of GPs refers to the percentage change in the number of 'All qualified permanent GPs (excludes GPs in training grades and locums)'. The change in the number of patients comes from the 'Total number of patients' line in Table 5 of the GP Workforce bulletin tables. The starting date for both of these time series is September 2015 because this is when the time series starts in that dataset.

Patient to GP ratio by decile of deprivation (Figure 1.20)

For this we use a snapshot of the number of patients and the number of fully qualified, permanent GPs in March 2016 and March 2023, to account for any seasonality in either number. To find how many GPs and patients there are in each decile of deprivation, we use the practice postcode to place a practice into a lower layer super output area (LSOA). We then use the English indices of multiple deprivation at a LSOA level to

assign a decile of deprivation to each practice. From there it is possible to sum both the patients and the number of fully qualified permanent GPs and then divide the former by the latter to come to a patient–GP ratio.

2. Hospitals

Seasonal trend lines (multiple charts)

For multiple charts (Figures: 2.15, 2.16, 2.23, 2.25, and 2.27) in this chapter we use seasonal trend lines to show the likely path of activity or performance for a given indicator in the absence of Covid. These are calculated in multiple stages. First, we calculate the monthly total over the previous 12 months for every month of data before February 2020 (the last month of data that is mostly unaffected by Covid). Second, we calculate the average monthly change in activity between the first 12-month average and February 2020. Third, we then divide the monthly actual by the 12-month average for that month to show the performance against the average. Fourth, we then average these monthly performances to create an average multiplier vs the 12-month average for every month of the year. Fifth, we then strip out the trend growth by normalising these monthly multipliers, by dividing each one by the average multiple across all 12 months.

We then start the trend line in March 2020. We calculate the trend by multiplying the 12-month average activity to February 2020 by the average monthly change for that activity type, risen to the power of the number of months past February 2020 (for example, for May 2020, the power would be 3). We then give that trend change a seasonality by multiplying it by the normalised multiplier for the relevant month.

Hospitals beds occupied by Covid patients (Figure 2.3)

This shows a rolling seven-day average. For the value shown on a given day, it is the average number of beds occupied by Covid patients in the previous seven days.

Change in doctor and nurse numbers (Figure 2.4)

Nursing numbers include adult and children’s nurses who work in hospitals, but do not include community nurses from the ‘NHS workforce statistics’ dataset. Doctors numbers include all those in the HCHS dataset.

Net nurse & health visitors and doctors joiners and leavers (Figures 2.5 and 2.6)

These charts show headcount, rather than FTE. The ‘EEA’ category is the sum of the European Union and the European Economic Area totals. The net number is calculated by subtracting the number of leavers from the number of joiners. A net negative number therefore shows there were more leavers than joiners in the previous 12 months.

Rolling average of NHS vacancy rates, by type of role (Figure 2.7)

The vacancies dataset gives the number of vacancies and the proportion of vacancies at the end of each quarter. To smooth out seasonal variation, we calculated a rolling 12-month average. We did this by first calculating the implied headcount for a given quarter, which is the number of vacancies divided by the proportion of vacancies. For

the full 12-month average, we then average the number of vacancies for the previous four quarters and average the implied headcount for the previous four quarters, then divide the former by the latter.

Rolling average of the hospital and community workforce resigning in the previous 12 months, by reason (Figure 2.8)

For this chart, we group some of the voluntary resignation categories from the 'NHS workforce, reasons for leaving' dataset to make the chart easier to read. The groupings are as follows:

- Work–life balance: this includes just the 'work–life balance' category from the original dataset, as this is the category that we want to highlight.
- Working conditions: this includes the 'better reward package' and 'incompatible working relationships' categories.
- Career development: this includes the 'lack of opportunities', 'promotion' and 'to undertake further education and training' categories.
- Family/external: this includes the 'adult dependants', 'child dependant', 'health' and 'relocation' categories.
- Other/not known: this includes only the 'other/not known' category.

Rolling average of NHS staff staying in post over the previous 12 months (Figure 2.9)

In this chart, the 'Nurses and health visitors' and the 'Total' are taken straight from the 'HCHS staff in HCHS trusts – turnover tables'. For HCHS doctors we exclude foundation year 1 and 2 doctors because they frequently leave roles as part of their rotations.

Proportion of NHS staff days lost to mental ill health (Figure 2.11)

This sums the total number of days lost to the reasons classified as 'S10 Anxiety/stress/depression/other psychiatric illnesses' in a given calendar year and divides them by the total number of available staff days in that financial year.

NHS staff absence, by reason (Figure 2.12)

'Mental health' refers to the reason classified as 'S10 Anxiety/stress/depression/other psychiatric illnesses'. 'Respiratory and other infectious diseases' is the sum of: 'S13 Cold Cough Flu – Influenza', 'S15 Chest & respiratory problems' and 'S27 Infectious diseases'. 'Other' is the sum of all the remaining reasons for absence (with the exception of unknown, which is captured in its own category).

Real-terms change in NHS staff earnings, by staff group (Figure 2.13)

'Consultants', 'Nurses & health visitors' and 'All staff' have been taken directly from the dataset. 'Ambulance staff' is a combination of the staff groups 'Ambulance staff' and 'Support to ambulance staff' from the dataset, weighted by the size of the workforce in each month. We combined these staff groups because some staff were reallocated from the former to the latter in April 2019, which made it appear as though ambulance

staff pay rose dramatically. For 'Junior doctors', we combined the 'Foundation Doctor Year 1', 'Foundation Doctor Year 2', 'Core training' and 'Specialty registrar' staff groups, weighted by size of the staff groups in a given month. We chose these four because

these are the staff groups that the BMA uses as a proxy for junior doctors. We deflated staff earnings by CPI, which is a more realistic index of the costs that an individual faces than the GDP deflator.

Ambulance arrivals resulting in a handover delay of 30+ minutes during winter peaks (Figure 2.24)

This is a rolling seven-day average of ambulance handovers resulting in a delay of 30-60 minutes, >60 minutes, and ambulance arrivals. The percentage is the sum of the first two divided by the third.

Hospital activity in the previous 12 months compared to the 12 months to February 2020 (Figure 2.28)

For each of these types of activity we calculated the total activity in the previous 12 months for every month to August 2023 and then divided that by the activity in the 12 months to February 2020.

NHS beds (Figure 2.29)

This shows the average number of each category of bed across the four quarters worth of data for a given year. For 2023/24, there is only one quarter's worth of data so this is the total for that financial year. The number of 'general and acute (G&A) overnight' and 'day only' beds are given in the dataset, as is the total number of beds. 'Other' is the difference between the total number of beds and the sum of G&A overnight and day only beds.

Attendances and admissions at major A&E departments in the previous 12 months (Figure 2.32)

This shows the average number of type-1 A&E attendances and admissions in the previous 12 months for a given month, divided by the average number of the respective metric in the 12 months to February 2020.

Change in the number of managers per FTE NHS staff member (Figure 2.33)

We calculated the number of senior managers and managers per NHS staff on an FTE basis for every month of this time series. We then calculated how this changed over the course of the time series.

Gross capital formation in health care as a percentage of GDP, by OECD country (Figure 2.34)

The weighted OECD average is calculated by first calculating the total spent on gross capital formation in every year by multiplying the percentage given in the dataset by the GDP number for the relevant year. This is then summed and divided by the sum of GDP for every country that has a data point in that year. Any country that does not have a data point in a given year is excluded from the analysis for that year.

Hospital diagnostic equipment per million population, by OECD country (Table 1)

The OECD average in this table is calculated as an average of the OECD countries in this table, weighted by the size of their population.

Diagnostic tests conducted, March to July 2023 (Figure 2.36)

Diagnostic tests conducted in 'non-community diagnostic centre locations' is calculated by subtracting the number of tests conducted in community diagnostic centres from the total number of tests conducted in a given month in hospital and community settings.

Procedures conducted by independent providers, by specialty (Figure 2.38)

This is the sum of all admitted and non-admitted pathways by independent service providers in 2022/23 divided by the sum of all completed pathways in that year.

3. Adult social care

Spending on adult social care (Figure 3.1)

The data point for 2022/23 is the actual spend on adult social care, as outlined in Table 5 of Appendix B of the 'Adult social care activity and finance report, England – 2022-23' (ASCAFR) dataset. We use this time series rather than the spend on adult social care as outlined in the local authority revenue outturn dataset because it captures a wider range of spending on the service than just local authority related spending. To calculate the forecast spend in 2023/24, we average out two methods. For both methods, we use the 'Revenue Account Budget' (RA) – which is the amount that local authorities forecast that they will spend in a given financial year. While this means that the forecast amount spent in 2023/24 will not be completely accurate, we feel that it is a fair assumption as the amount that local authorities spent on adult social care accounts for approximately 90% of the amount spent on adult social care in the ASCAFR dataset.

For the first method, we use 2021/22 ASCAFR spending as the baseline, and we uplift that amount by the percentage change between that year's 'Revenue outturn' (RO) and the 2022/23 and 2023/24 RAs.

There has subsequently been another ASCAFR release for 2022/23, but no RO for 2022/23. The ASCAFR spending came in slightly higher than the first method forecast for 2022/23. We assumed that not all of that spending will be exceptional and will likely imply higher than expected spending in 2023/24, meaning that the first method would likely underestimate 2023/24 spending.

We then used the second method, which was to apply the percentage uplift between the 2022/23 RA and the 2023/24 RA to the 2022/23 ASCAFR outturn. But we then assumed that this would overstate the amount spent on the service in 2023/24. We therefore decided to average out the 2023/24 forecasts for both methods to try and balance the respective under and over forecast.

Cost pressures on 2023/24 uplift in spending on adult social care (Figure 3.3)

The total spending increase for 2023/24 comes from the calculation described in the methodology for Figure 3.1. To calculate the impact of the national living wage (NLW), we assume that 70% of the total spent on the sector in 2022/23 goes on wages – a figure that comes from interviews with reliable stakeholders. We then assume that 65% of that total is spent on staff who receive the NLW, an assumption that comes from the Care Policy Evaluation Centre’s work. We then increase this amount by the NLW increase for 2023/24 (9.7%). The difference between the 2022/23 and the 2023/24 NLW is the impact of the increase of the NLW.

For the impact of ‘other wages’, we take the remainder of the wage bill that is not related to the NLW and increase it by 6%, which is the Bank of England’s assumption for economy-wide wage growth for this financial year.

To calculate non-wage inflation, we take the remaining spending on adult social care after wages have been taken out and increase it by the GDP deflator forecast for 2023/24 from the OBR’s *Economic and Fiscal Outlook* from March 2023.

To calculate the demographic demand pressure, we take the total spending for 2022/23 and increase it by the forecast increase in the size of the over-65 population in England for the year, then subtract the former from the latter. This likely underestimates the true impact of demographic demand on the service as demand from working-age adults is rising more quickly and is more costly than increases in demand from the over-65 population. It is, however, difficult to estimate the demand for working-age adults so we have decided to provide a more cautious estimate.

Adult population providing 20+ hours per week of unpaid care by local authority deprivation (Figure 3.10)

We calculated the proportion of the population of each upper- and single-tier local authority that provides 20–50 hours and 50+ hours of unpaid care per week and then summed them to come to a total proportion of the population that provides 20+ hours of care per week. We replicated the calculation for 2011 and 2021, with different populations depending on the year. We then matched these percentages to the level of deprivation in the 2019 English indices of multiple deprivation.

Change in proportion of the population accessing long-term support since 2014/15, by age group (Figure 3.13)

We took the total number of people receiving long-term care at the end of the financial year and divided this by the relevant population group for each year to come to a ‘per-capita number of people in long-term care’. We then calculated the percentage change for working-age adults and adults over 65 to show the change compared to 2014/15.

Change in the means test for publicly-funded care, compared to inflation (Figure 3.15)

To calculate the level the means test would have been if it had risen in line with inflation, we multiplied the base year (2009/10) by the consumer price index for a given year to show how it would have progressed.

4. Children's social care

Change in local authority spending on children's social care in England since 2009/10 (real terms) (Figure 4.1)

The data point for 2021/22 is the actual spend on children's social care, as outlined in the DfE's 'Local authority and school expenditure 2021 to 2022' dataset. We use this time series rather than the spending on children's social care as outlined in the local authority revenue outturn dataset because it captures a wider range of spending on the service than just local authority related spending. To calculate the forecast spend in 2022/23, we calculate the change in spending between the amount spent on children's social care in 'Revenue outturn social care and public health services (RO3) 2021 to 2022' and the amount that local authorities were forecast to spend on children's social care in 2022/23 and 2023/24, as outlined in the 'Revenue account budget 2022 to 2023' document. We then take this percentage change and apply it to the amount spent in 2021/22 from the DfE figures. While this means that the forecast amount spent in 2022/23 and 2023/24 will not be completely accurate, we feel that

it is a fair assumption as the amount that local authorities spent on children's social care in 2021/22 (£10.4bn) accounts for approximately 99% of the £10.5bn spent on children's social care in the DfE dataset.

Children entering care who are unaccompanied asylum-seeking children, 2009/10–2021/22 (Figure 4.7)

For a given year-end data point, we have taken the number of unaccompanied asylum-seeking (UAS) children that become 'looked after children', released via an FOI request, as a percentage of the total number of new looked after children from the DfE's dataset, 'Children looked after in England including adoptions: reporting year 2022'.

Number and proportion of children in care who are unaccompanied asylum seekers by local authority, 31 March 2022 (Figure 8)

The proportion of children in care who are unaccompanied asylum-seekers has been calculated by taking the total number of asylum-seeking children who are looked after children as a proportion of the total number of looked after children for a given local authority. This was then plotted against the total number of UAS children for each local authority that had complete data. Fourteen local authorities lacked data on the number of UAS children and an additional local authority did not report a figure for the total number of children in care. Each of these local authorities was excluded from this analysis.

5. Neighbourhood services

Local authority spending, 2009/10–2021/22 (2023/24 prices) (Figure 5.1)

Figures have been deflated using the smoothed deflator described at the start of the Methodology chapter.

Local authority spending on neighbourhood services 2009/10–2021/22 (2023/24 prices) (Figure 5.2)

The data for 2009/10 is inflated due to Revenue expenditure funded from capital by statute (RECS) which across all local authority expenditure for the year amounted to £1.8bn. It is not possible to remove this from individual service lines. For further details see Table 2 'Revenue expenditure and financing 2008-09 and 2009-10' in Local Authority Revenue Expenditure and Financing England 2009-10 Final Outturn (revised) 27 January 2011 available at: <https://assets.publishing.service.gov.uk/media/5a79a57940f0b63d72fc7676/1826743.pdf>

Median un-ringfenced reserves as a percentage of service expenditure, by local authority type, 2017/18–2021/22 (Figure 5.3)

Reserves analysis has been carried out on a new dataset released by DLUHC: 'Local authority general fund earmarked and unallocated reserve levels, 2017–18 to 2021–22'.

These figures differ from DLUHC revenue expenditure and financing revenue outturn data, which represents the unadjusted reserves position. The department has explained that "unadjusted reserves figures are higher than normal for many authorities in 31 March 2021 and 31 March 2022".¹² This was due to emergency government support used to compensate for lower business rates income due to the Covid-19 business rates reliefs (expanded retail relief and Covid additional retail relief).¹³ As the department explains: "Accountancy regulations require that this grant income is included in local authorities' revenue accounts. These are shown in 'other earmarked reserves' until the following year when they compensate for what would otherwise be lower retained business rates income."¹⁴

The figures reported in this new data series have been adjusted by the department to remove the distortionary effects on reserves data linked to the timing of emergency Covid grants including business rate reliefs. For further details see <https://www.gov.uk/government/publications/local-authority-general-fund-earmarked-and-unallocated-reserve-levels-2017-18-to-2021-22>

6. Schools

Per-pupil funding, 2010/11–2023/24 (2023/24 prices) (Figure 6.2)

Figures have been deflated using the smoothed deflator described at the start of the Methodology chapter.

Median teacher pay by role, 2010–2022 (2022 prices) (Figure 6.7)

Figures have been deflated using CPI figures from the spring budget, as a better estimate of the cost pressures teachers face than the GDP deflator.

Attainment at the end of primary and secondary school in state-funded schools, 2010–2023 (Figure 6.11)

All figures include those not in mainstream education.

Primary: KS2 assessments were reformed between 2015 and 2016, and did not take place in 2020 and 2021.

Secondary: between 2013 and 2014 a number of changes were made to secondary qualifications. In 2017 reformed English and maths GCSEs were awarded for the first time; in 2020 and 2021 GCSE results were awarded on the basis of centre-/teacher-assessment rather than external assessment; in 2022 GCSE results were set between pre-pandemic, 2019 levels and 2021 levels; in 2023 grades were allowed to return to pre-pandemic levels, with some grading protections to ensure they were not below 2019 levels.

7. Police

Spending on police, 2009/10–2022/23 (2023/24 prices) (Figure 7.1)

To project spending for each year between 2023/24 and 2024/25, the previous year's spending total is multiplied by the planned percentage increase in Home Office spending between the two years. These figures can be found in Table 2.1 of the autumn statement.¹⁵ This step is repeated for each year in the forecast.

Figures are deflated using a smoothed GDP deflator, which arrives at a figure for 2020/21 by averaging figures from 2019/20 and 2021/22.

Victim-reported crime methodology change (Figures 7.2 and 7.3)

The Crime Survey in England and Wales (CSEW) suspended face-to-face interviews on 17 March 2020 due to the pandemic. From the year ending June 2020, data tables include data from the Telephone-operated Crime Survey in England and Wales (TCSEW). These do not include crimes experienced by children aged 10 to 15 years. Further details are outlined in ONS, 'User guide to crime statistics for England and Wales: measuring crime during the coronavirus (COVID-19) pandemic', 21 July 2022, retrieved 7 October 2022, <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/methodologies/userguidetocrimestatisticsforenglandandwales/measuringcrimeduringthecoronaviruscovid19pandemic>

The CSEW figures used in these charts are taken from 'Worksheet A1' of ONS, 'Crime in England and Wales: Appendix tables'. The figures for 2022/23 are comparable with the entirety of the time series *included within this worksheet* (that is, comparable with figures before the methodology change). It would not, however, be appropriate to draw comparisons between this worksheet and the corresponding worksheet in previous editions of the dataset published prior to the methodology change.

Charges/summons recorded by police forces, 2009/10–2022/23 (Figure 7.4)

Charge/summons figures are taken from two sources. Figures for 2009/10 to 2017/18 are taken from Home Office, 'Crime outcomes in England and Wales' (Table B2),

2022/23. Figures covering 2018/19 to 2022/23 are taken from the Home Office's 'Police recorded crime and outcomes data tables'. Table B2 in the former source stopped publishing figures for all forces from 2018/19, and instead excluded Greater Manchester and Devon & Cornwall police forces. This was due to the desire to compare the numbers between like-for-like forces from this date onwards, since Greater Manchester and Devon & Cornwall experienced issues submitting figures in 2019/20 and 2022/23 respectively. Using the latter source allowed us to include what figures *were* submitted by these forces in our chart. We have highlighted these issues in the chart notes.

This poses a potential problem when we claim that the increase in the number of charges in 2022/23 is "the first increase... since 2013/14". While the data does not definitively support this claim (given the missing Greater Manchester data in 2019/20) we feel it is a fair one to make, since if this claim were *not* true (that is, if Greater Manchester recorded enough charges in 2019/20 to make overall levels at least equal to 2018/19 figures), it would have had to record double the number of charges it made in 2018/19. This would be extraordinary in itself, but also contrary to the trend in Greater Manchester's charges between 2012/13 and 2020/21.

Public perception that local police are doing a good or excellent job, 2009/10–2021/22 (Figure 7.7)

Supplementary tables were not published as part of the CSEW in 2020/21 or 2021/22, as the new telephone survey limited time and questionnaire length. As a result, not all of the usual questions were asked to all participants. Data for a similar question, on rating the local police, is available for each quarter, however. The 2022 figure represents the average of responses from each quarter.

8. Criminal courts

Spending on HMCTS, 2010/11–2022/23 (2023/24 prices) (Figure 8.1)

To project spending for each year between 2023/24 and 2024/25, the previous year's spending total is multiplied by the planned percentage increase in justice spending between the two years. These figures can be found in Table 2.1 of the autumn statement.¹⁶ This step is repeated for each year in the forecast.

Figures are deflated using a smoothed GDP deflator, as discussed at the start of this chapter.

Case backlog in the crown court, Q1 2010 to Q2 2023 (Figure 8.9)

The latest official statistics for the backlog in the criminal courts are taken from the Quarterly Criminal Court Statistics up to March 2022. We calculate a backlog adjusted for complexity in three stages:

- We calculate the number of jury and non-jury disposals that are missing by assuming that the share of cases coming into the crown court since March 2020 that end up as jury trials is the same as pre-Covid. The 'missing' cases are then the gap between those assumed to be entering the courts system and those that are completed each quarter.

- We treat jury trials and other cases separately. We multiply the 'missing' number of both by [share of total hearing time]/[share of total cases] to get a complexity-weighted increase in the backlog.
- An 'ordinary' backlog is more complex than the average of cases processed (specifically, more cases that will end up as a jury trial), so to adjust this number to be consistent with the pre-Covid backlog we multiply it by [average hearing time of backlog case mix]/[average hearing time of all cases].

9. Prisons

Spending on prisons, 2009/10–2021/22 (2023/24 prices) (Figure 9.1)

To project spending for each year between 2022/23 and 2024/25, the previous year's spending total is multiplied by the planned percentage increase in justice spending between the two years. These figures can be found in Table 2.1 of the autumn statement.¹⁷ This step is repeated for each year in the forecast.

Figures are deflated using a smoothed GDP deflator, as discussed at the start of this chapter.

Prison population and capacity, 2011–2023 (Figure 9.3)

The monthly data releases cited give a number of figures, including:

- In Use CNA: the sum total of certified normal accommodation in all establishments minus a) (normally) cells in punishment or segregation units and health care cells or rooms in training prisons, and b) those places not available for immediate use
- Operational capacity: the total number of prisoners that an establishment can hold taking into account control, security and the proper operation of the planned regime.
- Useable operational capacity: operational capacity minus an 'operating margin' that reflects the constraints imposed by the need to appropriately accommodate different classes of prisoner (for example, by sex, age, conviction status, single cell risk assessment, geographic distribution and security category).

In this graphic, the 'maximum capacity' ribbon represents the space between the latter two figures. In any given monthly data release, either the total operational capacity or useable capacity is given, along with the useable capacity margin in the notes. In cases where the total operational capacity is published, the useable figure is calculated by subtracting the margin from the total. In cases where the useable capacity is published, the total figure is calculated by adding this figure to the published margin.

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