INSTITUTE FOR GOVERNMENT

Methodology

Public services performance tracker 2025: the NHS

General

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 (OBR) in the Economic and Fiscal Outlook from March 2025.[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 the entire report to 2025/26 prices. There are some instances throughout where we put spending into prices from a year other than 2025/26. Where this is the case, we explain our reasoning in the Methodology below.

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 (CPI) rather than the GDP deflator. The CPI that we use also comes from the OBR's Economic and Fiscal Outlook from March 2025.

Institute for Government interviews

For this report, we conducted around 35 interviews between June and August 2025 with various relevant stakeholders, including subject experts from civil society organisations, civil servants and frontline staff.

Interpreting regression results

Throughout the report, we use univariate and multivariate regression analysis to identify relationships between variables. These regressions do not let us say that one variable causes another, but they do let us see if a high level in one variable tends to occur with a high or low level in another.

Regression tables included in this report should be interpreted as follows:

- The dependent variable (the factor being measured) is listed along the top of the table. There is always exactly one dependent variable per regression.
- The independent variables (the factor we are testing the effect of on the dependent variable) are listed in the 'Independent variable' column. There may be more than one independent variable per regression.
- At the intersection between an independent and dependent variable is the coefficient on that independent variable. This shows the unit change in the dependent variable associated with a one-unit higher independent variable, holding all other independent variables constant.
- We use asterisks to represent the level of significance of an independent variable, as determined by the p-value from our regressions. Three asterisks signify the highest level of significance and one asterisk the lowest.
    - The thresholds are as follows:
      * Weakly significant: $0.01 < p < 0.05$
      ** Moderately significant: $0.001 < p < 0.01$
      *** Highly significant: $p < 0.001$
      A dot signifies that a variable has fallen just short of significance ($0.05 < p < 0.1$).
- We also report the R^2 for univariate regressions (those with only one independent variable). This is the proportion of the variation in the dependent variable that can be explained by variation in the independent variable.

Chapter NHS 1 – NHS overview

Figures NHS 1.1: NHS elective procedures cancelled or rescheduled per resident doctor on strike, by round of strike action, March 2023 to July 2025

This data comes from the NHS's analysis of the impact of industrial action by resident doctors. The NHS publishes data for each round of strike action which shows the total number of doctors absent from work because of industrial action on each day and the number of elective procedures and appointments scheduled to take place that day that that were rescheduled because of industrial action. For each period of industrial action, we divided the sum of the latter by the sum of the former to give the number of elective procedures and appointments per doctor on strike.

Chapter NHS 2 – General practice

Figure NHS 2.1 Spending on general practice, actual and projected, 2009/10–2025/26 (2025/26 prices)

All data before the "IfG projection" line comes from the 'Investment in general practice' dataset. Due to the delayed publication of this dataset, 2022/23 is the most year for which there is data.

The "Total excluding Covid" series comes from the line item "Total Spend Excluding Covid-19 Related Costs".

The "Total including Covid spending" is the above data plus the two line items related to Covid income: "COVID-19 Support Fund, COVID-19 Expansion Fund and Other COVID-19 Related Costs" and "COVID-19 Vaccination Programme Costs"

To calculate the line called "Total excluding Covid and primary care network spending" line, we took the "Total excluding Covid" amount and subtracted the seven line items related to primary care networks. These are:

- Primary Care Network Leadership
- Primary Care Network Workforce
- Primary Care Network Extended Hours Access
- Primary Care Network Enhanced Access Service
- Primary Care Network Care Home Premium
- Primary Care Network Investment and Impact Fund
- Primary Care Network Support

These sum to the total in the line: "Primary Care Network DES Investment"

For the projections:

We assume that Covid income falls to zero from 2023/24 onwards

For the "Total excluding Covid and primary care network spending" we assume that spending in 2023/24 rises in line with the cash terms core contract funding increase outlined in the 2019 'Five-year framework for GP contract reform'.[2] That says that the cash terms increase for 2023/24 would be 2.7%. After adjusting for inflation in 2023/24, this comes to a 3.2% real terms decline.

For the "Total excluding Covid" projection in 2023/24, we added the forecast amount of PCN funding (£2.4bn) for 2023/24 to the amount calculated in the paragraph above to find total general practice spending.[3]

For the 2024/25, there is no estimate of the amount of funding for PCNs. We therefore stopped the "Total excluding Covid and primary care network spending" line in 2023/24.

For the "Total excluding Covid" line, we took an estimate of the increase in spending on general practice that came from the King's Fund.[4] That estimated that spending on the service would increase by 2.2% in cash terms, or -1.5% in real terms.

For the 2025/26 projection, we took the estimated increase in funding that came from the 2025/26 GP contract announcement (an additional £889m on £12.3bn of funding in 2024/25.[5] The government subsequently announced an additional £127m worth of funding to cover the increase in salaried GPs' wages in 2025/26, as a result of the government accepting the DDRB's pay recommendation.[6] This gave an 8.3% cash terms uplift in 2025/26, or 5.5% in real terms. We applied this change to our estimate of total spending on general practice for 2024/25 to come to our projection for 2025/26.

Figure NHS 2.2 Average payment per weighted patient in general practice, by patient list deprivation, 2013/14–2023/24 (2025/26 prices)

This data comes from the 'Payment to general practice' dataset.[7] We used the metric "Total payment to practices minus deductions". We used this metric rather than the one that includes deductions, because deductions include things like payments for pensions and professional levies which are paid to pension providers and professional bodies by the NHS on behalf of practices, meaning that practices never control that money. We divided this by the number of weighted patients in each practice in each year. We aggregated all the years' data into one time series for each practice.

We then used DHSC's Fingertips deprivation data[8] to allocate an index of multiple deprivation score to each practice. We ranked the practices based on deprivation and then sorted them into quintiles. We summed the total payments minus deductions and the number of weighted patients for each quintile and divided the former by the latter to come to the average payment for each quintile.

Figure NHS 2.3 Real-terms change in GP pay, actual and projected, since 2006/07

The time series for both GP partners and salaried GPs comes from the "GP Earnings and Expenses Estimates".[9]

We use the "Income before tax" metric for both partners and salaried GPs from table 1a for the former and 7a for the latter. We do not start the time series in 2002/03 for partners because there is no comparable data for salaried GPs. 2006/07 is the first year where there is comparable data.

We project salaried GPs' pay using the recommendations from the DDRB in 2024/25 and 2025/26, for a 6% and 4% increase in pay respectively. The government accepted the DDRB's recommendation in both years.

Figure NHS 2.7 Country where GPs received initial medical training, by patient list deprivation, March 2025

We used the 'General practice – March 2025 practice level – detailed' dataset. From this we split GPs into the countries in which they qualified. For example, to find the number of staff who completed their initial medial training in the UK, we took the GPs from the column called "TOTAL_GP_HC_COQ_UK".

We then assigned each practice a deprivation score, as described in figure NHS 2.2 and then summed the number of GPs from each country and by the decile of deprivation. We could then create three data buckets: UK, the EEA and then the sum of every other country for the 'Rest of the world'.

Figure NHS 2.9 GP leaver rate, by age group, September 2016 to September 2025

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 65, 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 (tovstal 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.

Figure NHS 2.10 GP leaver rate, by region and age group, 2024/25

We use the same methodology as for figure NHS 2.9, except we split it into regions

Figure NHS 2.13 GPs per 100,000 weighted patients, by patient list deprivation, March 2025

We took the number of salaried GPs, GP partners and GP trainees working in each practice, as well as the number of weighted patients for each practice and then assigned the practice a deprivation score based as with figure NHS 2.2. We then summed the number of each metric based on the decile of deprivation for each practice. We divided the number of GPs in each category by the number of weighted patients in each decile to come to the number of GPs per 100,000 weighted patients.

Figure NHS 2.14 NHS primary care staff, by staff group, September 2015 to June 2025

All staff are shown in terms of FTEs.

Data for the fully qualified GPs, nurses, and GP trainees comes directly from the NHS Digital GP workforce bulletin tables. For salaried GPs and nurses, we include those staff members that are employed in primary care networks. This therefore captures all staff in the wider primary care workforce.

For the direct patient care (DPC) staff, three approaches were used for different time periods:

- Between September 2015 and December 2018, the DPC staff shown on the chart are taken directly from the GP workforce bulletin tables. Given that

primary care networks did not exist at this time, this measure should capture all the DPC staff working in primary care.
- Between March 2019 and June 2021, the DPC staff are a combination of the GP workforce bulletin tables DPC staff and those from the primary care network workforce bulletin tables.
- From September 2021 onwards, the DPC staff comes from the primary care workforce – nurses, DPC and admin/non-clinical staff dataset.

Figure NHS 2.15 Appointments delivered in general practice in the previous 12 months, by staff group, August 2019 to September 2025

This data comes from the GP appointment dataset. For each staff group, it is the sum of the appointments that happened in both general practice (table 1a) and primary care networks (table 1b). We then sum the appointments for the previous 12 months, starting from August 2019 (the first month for which there was data for the previous 12 months).

Figure NHS 2.16 Change in number of GPs, GP appointments and appointments per GP, since December 2019

This takes the number of appointments calculated for figure NHS 2.15 and divides it by the average number of GPs over the previous 12 months to create the average number of appointments delivered by GPs for each month. We then calculate the change in the number of all three metrics since December 2019 (before appointment numbers were affected by the pandemic).

Figure NHS 2.18 Appointments in primary care by mode of delivery, September 2018 to September 2025

As with figure NHS 2.15, this shows the sum of appointments across both general practice and primary care networks, summed by the appointment mode. We then divide the total for each appointment mode by the total number of appointments in each month.

Figure NHS 2.20 General practice appointments delivered by video or online, by use of online appointments, October 2022 to September 2025

We created a time series of the total number of appointments and the number of appointments delivered online for each practice between October 2022 (the first month where there is practice level appointment data) and September 2025. We then calculated the proportion of each practice's appointments that were delivered online in the 12 months to September 2025.

We then put each practice into a percentile from highest to lowest proportion of appointments delivered online. This gave us the practices that were in the top 10% of appointments delivered online in the 12 months to September 2025.

For those practices and the remaining 90%, we calculated the proportion of appointments that they delivered online in every month between October 2022 and September 2025.

Figure NHS 2.21 Change in the total number of appointments delivered in general practice, by use of online appointments, September 2023 to September 2025

We used the same 10% cohort for this as described in figure NHS 2.20. We then split the bottom 90% of practices into two cohorts. One is the practices that delivered no appointments online in the 12 months to September 2025 (29.8% of practices for which there is data).

For each cohort, we calculate the number of total appointments that they delivered on a rolling 12-month basis, we then calculated the change in the number of total appointments for each month up to September 2025, compared to September 2023 (the first month for which there is at least 12 months' worth of data).

Figure NHS 2.23 Patients satisfied with their GP practice, by patient list deprivation, 2012–25

We took the number of responses to the question for each GP practice in each year and the number of patients rating satisfaction with their GP practice as "Very good" or "Fairly good". We summed each of these by quintile of deprivation, in the same way as described for figure NHS 2.2. We then divided the sum of the positive responses by the total responses to give a proportion for each quintile in each year.

Chapter NHS 3 – Hospitals

Seasonal trend lines (multiple charts)

For multiple charts (Figures NHS: 3.31, 3.34, 3.46 and 3.54) 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 multiplies, 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.

Figure NHS 3.1: Average annual real-terms change in UK spending on health, by government, actual and projected, 1950/51–2028/29

This shows health spending in each financial year from 1950/51. For data before 1978/79, we took the data from the Office of Health Economics report 'OHE Guide to Health and Health Care Statistics – second edition'.[10] Between 1978/79 and 2008/09, we use data from the Institute for Fiscal Studies.[11] Between 2009/10 and 2024/25, we use data from HMT Public Expenditure, table 5.2.

We then deflate the cash terms amounts using the ONS's GDP deflator. There is no GDP deflator for financial years before 1955/56. For 1950/51 to 1954/55, we take the GDP deflator for the calendar year that has the largest overlap with the financial year, for example, we apply 1950 to 1950/51.

We group years by the party that was in power. So the first Conservative block includes governments that were led by Churchill, Eden, Macmillan, and Douglas-Home. For the base year of each period, we use the financial year before control of the government changed hands. For example, the first block of Labour spending, refers to the first Wilson government, which came to power in October 1964, we

used 1963/64 as the start year. We use the last full financial year that they were in power as the end point of the period. So to use the same example, Wilson left office in June 1970, so we use 1969/70 as the end point of that period and as the start point of the subsequent Conservative period.

For the IfG projection (which goes from 2023/24 to 2028/29) we assume that health spending rises in line with the government's settlement for the Department of Health and Social Care (DHSC) in that time, which was 2.7% per year in real terms as laid out in the 2025 Spending Review.[12]

Figure NHS 3.2: Spending on NHS hospital trusts, actual and projected, 2009/10–2028/29 (2025/26 prices)

For the IfG projection, we assume that spending on hospital trusts grows in line with the annual settlements for NHS England outlined in the 2025 spending review.[13] This does not account for larger increases in NHS funding going to non-hospital settings, as the government has claimed it wants to do. However, in the absence of any other indication of how the government intends to allocate funding, we think this assumption is defensible.

Figure NHS 3.6: Change in number of NHS hospital staff and completed elective cases, by ICB, January 2020 to January 2025

For the staffing numbers, we took the total number of full-time equivalent staff working in each integrated care board in January 2020 and January 2025 and calculated the percentage difference.

We did the same for the number of completed elective cases, though calculated the number of cases over the previous 12 months in each instance. We did this to avoid a single month making a large difference to the result. The one exception to this is Gloucestershire ICB, where there is no data for February 2019, meaning that we show only the eleven months to January 2020 and January 2025.

We conducted this analysis at an ICB rather than a trust level because there are large shifts in staffing and elective activity data at a trust level that is not due to mergers of trusts and is therefore difficult to account for in this time.

Figure NHS 3.7: Change in the number of NHS hospital staff and diagnostic tests, by ICB, January 2020 to January 2025

This is the same analysis as outlined for figure NHS 3.6, but instead of completed elective cases, we use diagnostic tests.

Figure NHS 3.8: NHS hospital beds, 1987/88–2024/25

For the years before 2019/20, there is annual data about the average number of beds. After that, data is published quarterly. We still show data in this chart on an annual basis, but we average the number of beds from each quarter across the 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.

Figure NHS 3.13: Change in NHS hospital doctor and nurse numbers since 2009

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.

Figure NHS 3.14: NHS hospital staff leaving the NHS in the previous 12 months, by staff group, September 2010 to June 2025

To calculate the leaver rate for staff groups, we divide the number of leavers in each 12-month period by the average of the "Denominator at start of period" and "Denominator at end of period".

The line called 'Ambulance staff' is the sum of the staff groups 'ambulance staff' and 'support to ambulance staff'. We combined these staff groups because some staff were reallocated from 'ambulance staff' to 'support for ambulance staff' in April 2019.

Figure NHS 3.15: NHS hospital vacancy rates, by type of role, March 2018 to June 2025

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 number of posts 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 total posts for the previous four quarters, then divide the former by the latter.

Figures NHS 3.16 and 3.17: Net change in NHS hospital doctors and nurses and health visitors in the previous 12 months, by nationality, March 2020 to June 2025

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.

Figure NHS 3.18: Real-terms change in NHS hospital staff pay, by staff group and compared to the wider economy, since March 2009

For the months after August 2010, we use the NHS's 'NHS staff earnings estimate' dataset. For the months between March 2009 and July 2010, we took the provisional estimates published in 2014.[14]

The staff groups nurses & health visitors, consultants, and all staff are given in the data set. 'Resident doctors' is the sum of 'Specialty registrars', 'Core training', 'Foundation year 1' and 'Foundation year 2' doctors. 'Ambulance staff' is the sum of the staff groups 'ambulance staff' and 'support to ambulance staff'. We combined these staff groups because some staff were reallocated from 'ambulance staff' to 'support for ambulance staff' in April 2019.

To calculate the pay for each of resident doctors and ambulance staff we weight pay in each month by the headcount of those staff.

For the 'Whole economy' line, we take the average weekly earnings in each month from the Office for National Statistics' dataset.[15] We calculate the average on a 12-month rolling basis and then we calculate the percentage change starting from March 2009.

All pay data is deflated using the consumer price index.

Figure NHS 3.19: NHS elective procedures cancelled or rescheduled per resident doctor on strike, by round of strike action, March 2023 to July 2025

This data comes from the NHS's analysis of the impact of industrial action by resident doctors. The NHS publishes data for each round of strike action which shows the total number of doctors absent from work because of industrial action on each day and the number of elective procedures and appointments scheduled to take place that day that that were rescheduled because of industrial action.

For each period of industrial action, we divided the sum of the latter by the sum of the former to give the number of elective procedures and appointments per doctor on strike.

Figure NHS 3.22: NHS hospital staff days lost to absence, by reason, 2015/16–2024/25

'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 (except for unknown, which is captured in its own category).

Figure NHS 3.24: NHS hospital staff days lost to sickness absence, by staff group, January 2016 to May 2025

The staff groups nurses & health visitors, consultants, and all staff are given in the data set. 'Resident doctors' is the sum of 'Specialty registrars', 'Core training', 'Foundation year 1' and 'Foundation year 2' doctors. 'Ambulance staff' is the sum of the staff groups 'ambulance staff' and 'support to ambulance staff'. We combined these staff groups because some staff were reallocated from 'ambulance staff' to 'support for ambulance staff' in April 2019.

Figure NHS 3.26: NHS hospital staff sickness absence rate, 2024, compared to deprivation of trusts' catchment area, 2019, by trust and reasons for absence

'Mental health' refers to the reason classified as 'S10 Anxiety/stress/depression/other psychiatric illnesses'. 'All other reasons' is the total number of days lost minus the days lost for mental health reasons.

To calculate the deprivation of a trust's catchment area, we took the following steps:

- We used the DHSC's "Acute hospital catchment populations" dataset to work out what proportion of each trust's catchment area comes from each MSOA.
- We then took the indices of multiple deprivation (IMD) dataset produced by MHCLG which are available at an MSOA level and we weighted the deprivation of each trust's catchment area by the proportion of that catchment area that comes from a particular MSOA

This then gave us an estimate of the IMD score for each trust which we then compared to sickness absence rates.

Figure NHS 3.29: NHS elective cases waiting less than 18 weeks, by trust, October 2017 to August 2025

For this, we include only acute trusts and only those that completed more than 5,000 elective cases in 2024/25. We did this because these are the most comparable trusts. Specialist trusts and trusts with small amounts of elective activity tend to have higher elective performance because they are managing smaller lists. Including them would therefore skew this analysis.

Figure NHS 3.32: Change in completed NHS elective cases, by trust, since December 2019

For this analysis, we once again only include acute trusts that completed more than 5,000 elective cases in 2024/25.

Trust mergers were an issue in this time series, because it created sharp discontinuities in activity. To circumvent this, we created "synthetic trusts" where possible. These synthetic trusts summer the activity from the trusts before they merged so that we could compare them to the merged trusts' activity at the end of the period.

In total, there were 10 synthetic trusts. These trusts were:

- South Tyneside and Sunderland NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- Hampshire And Isle of Wight Healthcare NHS Foundation Trust
- Somerset NHS Foundation Trust
- Mid And South Essex NHS Foundation Trust
- Bedfordshire Hospitals NHS Foundation Trust
- Guy's And St Thomas' NHS Foundation Trust
- University Hospitals Sussex NHS Foundation Trust
- Kingston And Richmond NHS Foundation Trust
- Royal Devon University Healthcare NHS Foundation Trust

Figure NHS 3.47: Proportion of attendances at major A&Es that waited less than four hours compared to attendances at major A&Es per 1,000 people, by trust, 2024/25

For this, we calculated the number of attendances per 1,000 people by taking the number of attendances in 2024/25 and dividing them by the number of people in the trust's emergency catchment area, as outlined in the DHSC's fingertips 'Acute hospital catchment populations' dataset. Given that the most recent data for this is from 2020, these populations may now be out of date, but we assume that populations will have grown at relatively equal rates across the country.

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