

Performance Tracker 2022

Public services after two years of Covid



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About Performance Tracker

Performance Tracker is an ongoing analysis of the performance of public services. This seventh 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.

Find out more:

www.instituteforgovernment.org.uk/performance-tracker

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Forewords

It gives me great pleasure to introduce the 2022 edition of *Performance Tracker*, though its findings are unfortunately far from encouraging. What is clear as public services try to recover from two years of the pandemic is that there will be no swift or easy return to normality.

Covid pressures persist across many if not all services, though down from the nadir of 2020 and 2021, and are now being compounded by a once-in-a-generation cost of living crisis, high inflation and growing demand. Services are facing interconnected structural failures with little prospect of meaningful improvement given funding and workforce constraints.

As with previous editions, we have analysed the spending, staffing, activities and performance of nine critical public services. This year we also, for the first time, provide a comprehensive cross-service analysis comparing and contrasting these services.

The Truss government faces difficult choices in its upcoming 'medium-term fiscal plan'; we hope this report will help it prioritise. What will be clear from reading it, though, is that there is no low hanging fruit if the government wishes to make cuts.

Performance Tracker would not be possible without the time provided by dozens of people working in public services who have spoken to us for this project. They have illuminated the data we cite, helping to make sense of a complex picture. We thank them for their help and hope readers find their insights as valuable as we did.



Dr Hannah White OBE, Director, Institute for Government

Soaring inflation means troubling times. Households will be making difficult decisions and millions will be forced to go without. The year ahead will bring considerable challenges for the new government, with the prime minister being forced to make many significant policy choices during the early stages of her premiership.

This seventh edition of *Performance Tracker* provides a snapshot of public services performance during a time of relative calm before the inflation storm. As economies around the world opened back up following the pandemic, public services faced significant challenges in coping with surging demand. Together with the Institute for Government, we have painted a comprehensive picture of that initial period of recovery and examined how different public services coped with the effects of the pandemic.

What it makes clear is that, despite spending on public services having increased massively during the pandemic, performance declined significantly. The prime minister will be judged not only on her ability to bring inflation under control, but also on improving public service performance levels.

A delicate balancing act will be required of the chancellor if the economy is to return to growth, people are to get the financial support they need throughout the winter and public services are to thrive once more.

I hope this report proves to be a good resource in analysing how public funding has affected performance across a cross-section of service areas, and will act as a roadmap to achieving better, more resilient services for communities throughout the country.

A handwritten signature in black ink that reads "Rob Whiteman". The signature is fluid and cursive, with a prominent flourish at the end of the name.

Rob Whiteman, Chief Executive, CIPFA

Summary

Public services are in a fragile state. Some are in crisis. Patients are waiting half a day in A&E, weeks for GP appointments and a year or more for elective treatments. Few crimes result in charges, criminal courts are gummed up, and many prisoners are still stuck in their cells under more restrictive regimes without adequate access to training or education. Pupils have lost months of learning, with little prospect of catching up, social care providers are going out of business or handing back contracts, and neighbourhood amenities have been hollowed out.

These are not isolated problems in individual services, but interconnected structural failures – particularly in the health and care and criminal justice systems. In many cases, there are too few staff, with excessive workloads, working on outdated equipment in run-down buildings.

These problems have been exacerbated by the Covid crisis but are not new. After a decade of spending restraint, public services entered the pandemic with longer waiting times, reduced access, rising public dissatisfaction, missed targets and other signs of diminishing standards. Less obviously, day-to-day spending on services had been shored up by transferring money earmarked for equipment, building maintenance and other capital projects. Governments since 2010 may have been seeking efficiency over resilience but achieved neither. And then Covid hit.

Services were heavily disrupted. Closures and reduced capacity resulted in growing backlogs, and increased pressure on already stretched workforces. Restrictions have now been lifted but things have not returned to the pre-pandemic 'normal'.

As such, the Truss government faces some very difficult decisions. Its fate at the next election will, in part, depend on how well public services have recovered from the pandemic – on whether crimes are being solved at higher rates, GP appointments can be booked and schools are well staffed. However, even stabilising some public services will cost billions, and tangible improvements will require even more. All this at a time when there are myriad demands for government support due to a once-in-a-generation cost of living crisis and war in Europe. Recent proposals to cut billions in taxes have done little to help the picture.

The Truss government previously promised to stick to the allocations set at the October 2021 spending review, meaning public services would be required to meet the cost of higher inflation and pay settlements from existing budgets. That would necessitate savings elsewhere, with further cuts possible in the upcoming 'medium-term fiscal plan'.

The analysis in this report outlines 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 in many cases interconnected, problems they face, and makes clear the consequences of spending choices the Truss government may take.

Most services do not have sufficient funding to return to pre-pandemic performance levels

The 2021 spending review was generous, relative to those since 2010, with budgets projected to increase by 3.4% per year on average for the nine services we cover. However, as a result of inflation and higher than anticipated pay awards, that has fallen to 1.5%. Even this could understate the costs facing public services as energy prices – which are largely excluded from this inflation calculation – will still affect public service providers even though a relatively small share of budgets is spent on energy.

As a result, the spending review settlement is now unlikely to be sufficient to meet growing demands and deal with the aftermath of Covid in most services. For example, spending per pupil will increase in schools, but will not be sufficient to recover the pandemic-induced lost learning. Likewise, hospital spending may be, just, sufficient to meet new demographic demand but will not allow for a big enough increase in activity to unwind Covid backlogs. In prisons and courts, new demand is set to exceed even generous spending settlements. Similarly, in combination, the spending settlement for local government is no longer sufficient to meet demand in adult social care, children's social care and neighbourhood services. Only in the police are budget increases enough to return performance to 2019/20 levels (though even then not to levels seen a decade earlier).

There is no meaningful 'fat' to trim from public service budgets. If the government wishes to make cuts in the medium-term fiscal plan, it must accept that these are almost certain to have a further negative impact on public services performance.

Backlogs have grown dramatically and will be difficult to tackle

In both hospitals and courts, measured backlogs are at historically high levels. Waiting lists for elective treatments stood at over 7 million people as of August 2022, the highest on record. In the crown court, the backlog stood at 59,700 cases in June 2022, slightly below the peak of over 60,000 in June 2021 but higher than at any point since at least 2000.

In both services, backlogs were already increasing before the pandemic. Waiting lists for elective surgeries had risen from 563,000 waiting 18 weeks for surgery in March 2019 to 860,000 in March 2020. Meanwhile, the crown court backlog increased from a low of 33,000 in March 2019 to almost 40,000 at the onset of the pandemic.

But even these headline figures, while striking, are likely to underestimate the true scale of the problem. In the case of courts this is because the backlog is disproportionately comprised of jury trials, which take far longer to hear; in the NHS, there may be potentially millions of people who are yet to come forward for treatment – or have failed to secure a timely appointment in the first place. The government has set out plans to tackle backlogs over the spending review period. But in each case it will be difficult to meet given current resourcing plans, even where those plans are relatively unambitious.

Perhaps the biggest problem is that backlogs can't generally be solved with one-off funding injections. In most cases, there simply aren't enough staff. Additional judges, doctors, nurses and social workers can't be magicked out of nowhere. Some staff can be tempted out of retirement or hired from overseas, but stabilising public service workforces requires a long-term strategy to boost recruitment and retain existing staff.

Below-inflation pay offers will exacerbate staffing problems

There are long-standing staff shortages across many public service professions, including nursing, criminal law and teaching. Covid-related absences have contributed to these pressures. In prisons, for example, higher levels of staff sickness have made it harder to fully lift Covid restrictions, with prisoners forced to spend more time in their cells than previously. In the NHS, the overall absence rate was worse in 2021/22 than in the first year of the pandemic. These pressures will not go away and may get worse as we head into winter. Staff absences affect the whole workforce, not just those taken ill, as reduced staffing levels increases the workload on other workers, and may have contributed to staff burn-out in public services.

These workforce problems have been exacerbated by the cost of living crisis. The worsening economic conditions, alongside below-inflation pay settlements, have increased the likelihood of strikes in key public services. In the short term, strikes will disrupt service delivery and efforts to reduce pandemic backlogs. In the long term, government will find it harder to retain well trained staff if pay and conditions in the private sector are seen as relatively more attractive.

Even below-inflation pay offers will stretch budgets. For example, the government's acceptance of the NHS Pay Review Body's recommendations will increase the NHS wage bill by approximately £2bn in 2022/23. This increase is unfunded, however, meaning that the NHS will have to find the money from the existing settlement, likely necessitating cuts elsewhere in the service.

Recommendations

Addressing these problems will not be easy and improvements will not happen overnight. There are, however, actions that the government can take now to set public services on the path to long-term sustainability. To that end, we recommend that:

- The prime minister should commit to publishing regular reports on existing and anticipated workforce shortages, with plans for how shortages will be addressed, for all of the services covered in this publication.
- The government should publish updated plans for how each service will tackle backlogs and unmet need, which include key milestones and assessments of the workforce and estate.
- The government should build on the processes used in the 2021 spending review to align spending with priority outcomes, using cross departmental outcomes to foster greater collaboration between departments and ensure that spending decisions are not siloed.
- The government should improve the range and quality of the data it collects on public services, with particular focus given to adult social care data.

Performance Tracker 2022: Cross-service analysis

Introduction

In 2019, the Conservative manifesto was clear about its public service priorities: increase spending and improve the performance in general practice, hospitals, police and schools. The pandemic certainly led to increased spending, with the government providing £17.8 billion more for these four services alone in 2021/22 than it did two years earlier. However, the performance of public services has declined markedly, also because of Covid.

Public services are now in a more fragile state than before the pandemic. They face higher costs due to inflation, are vulnerable to new variants of Covid, and the NHS and social care in particular expect a winter crisis following an already difficult summer. While the Conservative leadership contest and early weeks of the Truss government have focused on tax cuts, the new prime minister is likely to be judged by the public on her response to the cost of living crisis and the progress her government has made reducing waiting times and improving access to critical public services.

This year's *Performance Tracker* assesses how nine public services – general practice, hospitals, adult social care, children's social care, neighbourhood services, schools, police, criminal courts and prisons – have coped with the effects of the pandemic, and the outlook for the remainder of this parliament. For each service we have analysed how much was spent, how the nature of demand has changed, the impact on staff and the progress of efforts to reduce backlogs or address unmet needs where applicable. It opens with a cross-service analysis considering these factors together, assessing the increased use of technology during the pandemic and identifying systemic problems across the justice, health and local services sectors that need attention from government.

The new government faces tough decisions in its upcoming 'medium-term fiscal plan' and the subsequent spring budget. The fiscal landscape has become more difficult since the 2021 spending review and the chancellor will need to balance funding for public services, the level of taxation and borrowing – all within the context of inflationary pressures, exacerbated by the war in Ukraine, and higher wage demands that have reduced the real value of the 2021 spending decisions made by the then chancellor, Rishi Sunak. The analysis in this report outlines the current state of public services and the consequences of different spending decisions.

Table 0.1 Service RAG ratings, October 2022

Service	Performance on the eve of pandemic vs 2009/10	Ongoing direct impact of Covid on working practices	Current performance vs 2019/20 performance	Funding adequate to return performance to 2019/20 level	Workforce adequate to return performance to 2019/20 level
General practice	Red	Amber	Amber	Amber	Red
Hospitals	Red	Red	Red	Red	Red
Adult social care	Red	Amber	Amber	Red	Red
Children's social care	Amber	Green	Green	Red	Amber
Neighbourhood services	Amber	Green	Amber	Red	Amber
Schools	Green	Green	Amber	Red	Amber
Police	Amber	Green	Amber	Green	Green
Criminal courts	Amber	Amber	Red	Red	Red
Prisons	Red	Amber	Red	Red	Red

Source: Institute for Government analysis, supported by CIPFA.

Category	Criteria
Performance on the eve of the pandemic vs 2009/10^{1,8}	Green: Service performance (scope, quality and efficiency) on the eve of the crisis was the same or better than in 2010
	Amber: Service performance was somewhat worse than in 2010
	Red: Service performance was much worse than in 2010
Ongoing impact of Covid on working practices	Green: Working practices are no longer significantly directly disrupted by Covid (due to Covid-related staff absences, building closures or enhanced infection control measures)
	Amber: Working practices are somewhat directly disrupted by Covid
	Red: Working practices are extensively directly disrupted by Covid
Current performance vs 2019/20 performance	Green: Service performance (scope, quality – including backlogs – and efficiency) is the same or better than on the eve of the pandemic
	Amber: Service performance is somewhat worse than on the eve of the pandemic
	Red: Service performance is much worse than on the eve of the pandemic

* Where data permits, we use 2010 throughout this report as a comparison as this marks the end of 13 years of Labour governments and the beginning of 12 years of Conservative-led governments.

Funding adequate to return performance to 2019/20 level	Green: Accounting for cost pressures from pay and latest inflation, it is likely that the spending review 2021 settlement provides sufficient resources to enable the service to return to 2019/20 performance by 2025
	Amber: It is finely balanced or uncertain that the spending review 2021 settlement provides sufficient resources to enable the service to return to 2019/20 performance by 2025
	Red: It is unlikely that the spending review 2021 settlement provides sufficient resources to enable the service to return to 2019/20 performance by 2025
Workforce adequate to return performance to 2019/20 level	Green: It is likely that current government actions and plans will lead to sufficient recruitment and retention of staff to enable service to return to 2019/20 performance by 2025
	Amber: It is finely balanced or uncertain whether current government actions and plans will lead to sufficient recruitment and retention of staff to enable service to return to 2019/20 performance by 2025
	Red: It is unlikely that current government actions and plans will lead to sufficient recruitment and retention of staff to enable service to return to 2019/20 performance by 2025

The churn in government ministers has disrupted some public service reform plans

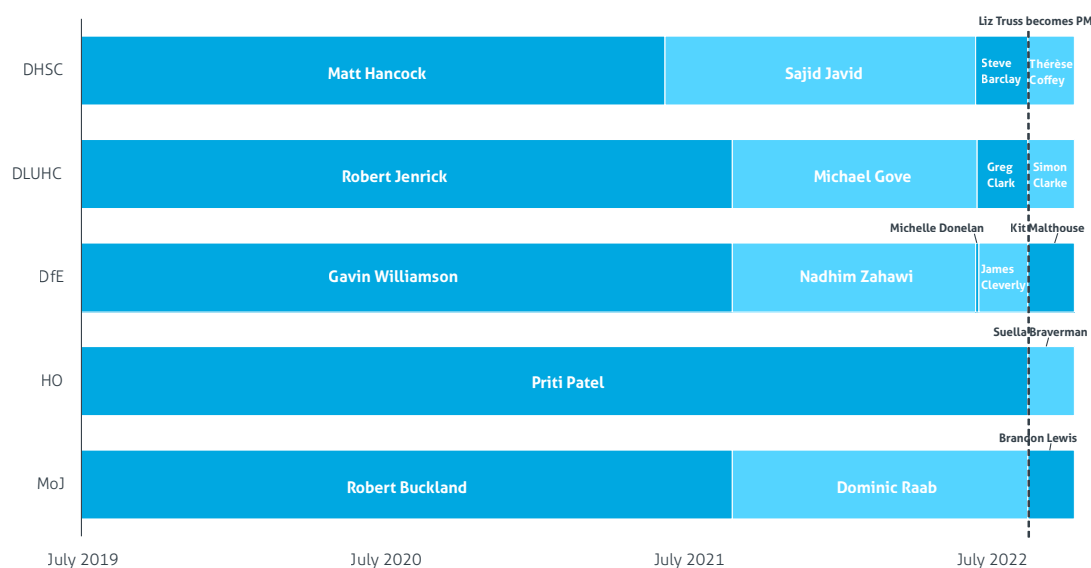
During 2022 there has been a threefold hit on government decision making. First, the formation of a new government in September led to considerable churn in ministers, with all but four of Liz Truss's cabinet new in post. This had been preceded by the resignation or sacking of no fewer than 30 ministers and appointment of replacements in the week before her predecessor, Boris Johnson, agreed to stand down in July. Such fast turnover leads to poor decision making.²

Second, while acting as caretaker during the eight-week Conservative leadership election, Johnson committed to not introducing any significant reforms, further impeding decision making.³

Third, though the government has not yet published concrete plans to implement the policy, the decision to reduce the civil service by 20% effectively reopened the 2021 spending review and disrupted departmental planning.

The churn at the centre of government has led to delays and changes in important policy areas. For example, the government was expected to publish a long-awaited health disparities white paper in 2022.⁴ However, it has been reported that the new health secretary has decided against publishing the paper.⁵ Similarly, the fate of the Schools Bill, which is yet to pass through the House of Commons, is unknown but could also be scrapped.⁶

Figure 0.1 **Secretaries of state in public service departments, 24 July 2019 to 14 October 2022**



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

Spending

Emergency Covid-support funding continued into 2021/22

Responding to Covid in 2020/21, the government significantly increased spending on public services compared to 2019/20, the last financial year prior to the pandemic, to support continuing service delivery in difficult circumstances.* For the nine services reviewed in *Performance Tracker*, £221.3bn was spent in 2020/21 and £222.9bn was spent in 2021/22, compared to £203.7bn in 2019/20.**

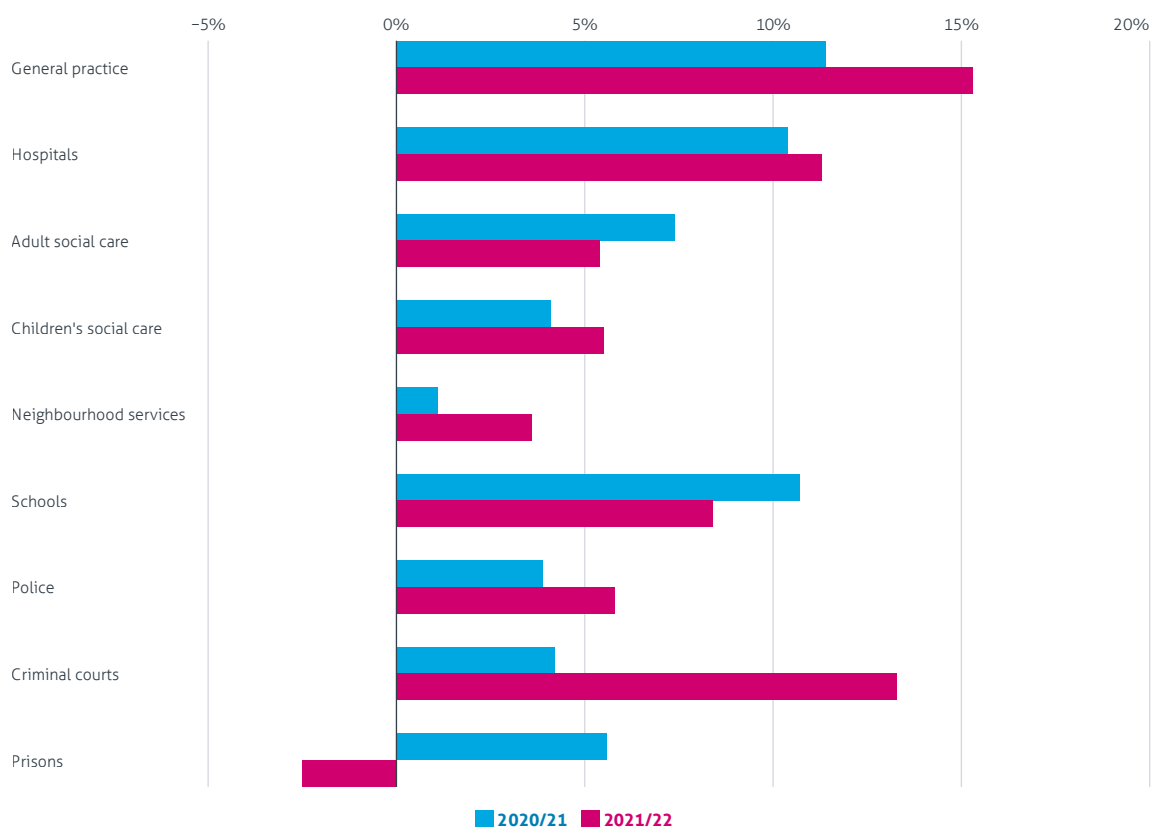
The public-facing nature of these public services meant considerable funding was required to ensure continuity of service in a Covid-secure way. Tens of billions of pounds in emergency Covid funds issued between 2020/21 and 2021/22⁷ had been spent on the nine services covered in the report (the rest was spent on things including Test and Trace, the Bounce Back Loan Scheme and the Coronavirus Job Retention Scheme or 'furlough').***

* Not all Covid support funding went to public sector bodies but rather to support the delivery of public services. For example, in adult social care, much of the additional funding went to private providers.

** Institute for Government analysis of government spending data, supported by CIPFA. Notes: Full details on data sources are provided in the methodology chapter.

*** It is not possible using the National Audit Office cost tracker to precisely identify spending on particular services. See National Audit Office, 'COVID-19 cost tracker, (23 June 2022) retrieved 22 August 2022, www.nao.org.uk/overviews/covid-19-cost-tracker

Figure 0.2 **Change in public services spending since 2019/20 (real terms)**



Source: Institute for Government analysis of government spending data, supported by CIPFA. Notes: Criminal courts figures for 2021/22 are based on in-year spending figures; other figures for 2021/22 are based on forecasts; see Methodology for further details.

Public services required extra spending to meet existing and additional responsibilities. For example:

- NHS trusts and foundation trusts received £2.1bn to cover lost income and 0.4£bn was provided for Nightingale hospitals.⁸
- Adult social care received £5.3bn between 2020/21 and 2021/22 to provide financial assistance to care providers, facilitate discharge from hospitals, and adapt settings to make them Covid-secure.⁹
- Children’s social care received 8.0£bn to cover additional accommodation and staffing costs.¹⁰
- General practitioners had an additional £0.7bn of Covid-specific spending allocated to them to cover the vaccine programme and other Covid costs in 2020/21.
- Schools were given £0.5bn for free school meal vouchers and £0.6bn for digital devices to enable remote learning.¹¹

Prisons were the only service with lower spending in 2021/22 than 2019/20. Day-to-day spending rose by 5.6% in 2020/21 as a number of Treasury-approved schemes were implemented to ensure the continued supply of staff. Spending is expected to have fallen almost 8% in real terms in 2021/22 as the Covid support measures came to an end.

In responding to a fast-moving situation the government, quite understandably, did not always get the most out of the extra money that was spent on services.* For example, £2.1bn was spent on support for the adult social care market to prevent providers going out of business – while necessary to assist during uncertainty, there is no clear way to evaluate whether this money was well spent. In the NHS, little use was made of a contract with independent providers to increase spare bed capacity in the first year of the pandemic, largely due to staffing constraints.¹²

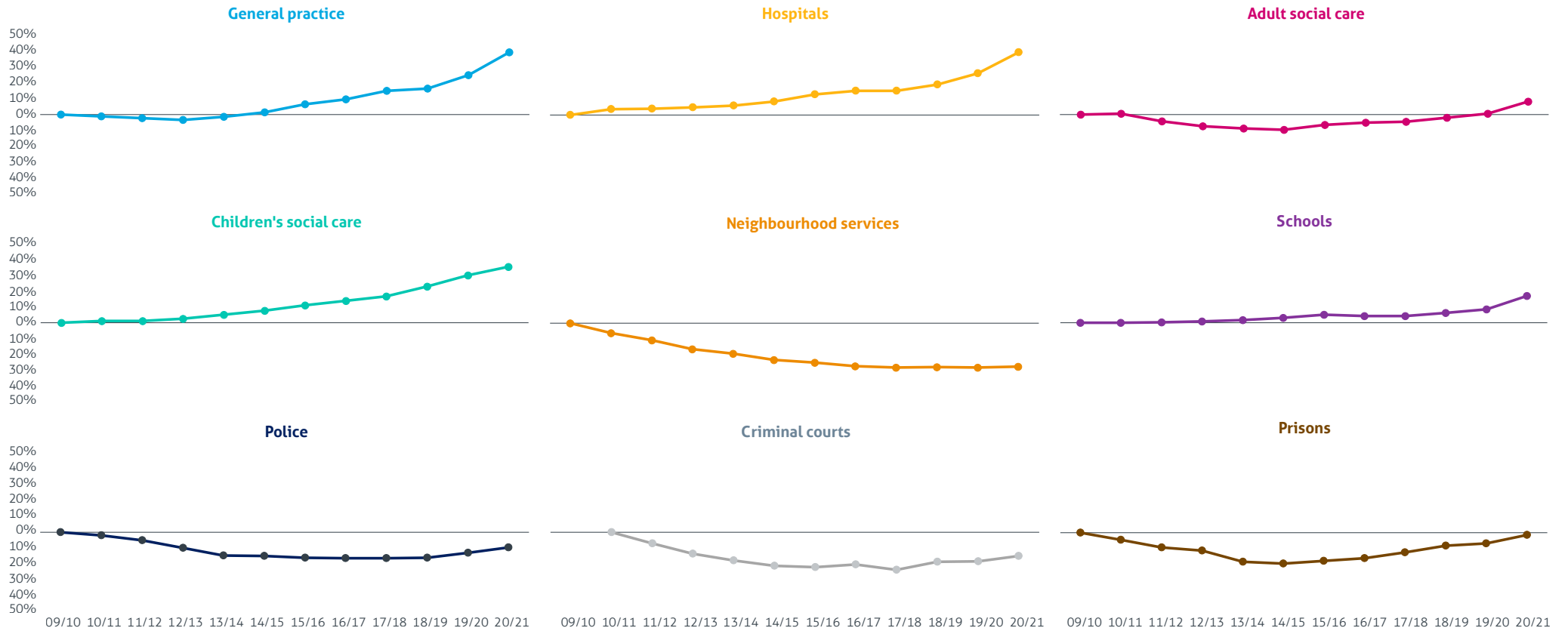
The 2021 spending review left some services with less money than in 2009/10

When the pandemic hit, many public services were in a precarious state following a decade of spending restraint.¹³ The 2021 spending review – conducted when Rishi Sunak was chancellor in Boris Johnson’s government but which the Truss government has indicated it will stick to¹⁴ – led to budget increases for most services yet this has not left them on a stable financial footing.

In the criminal justice sector, spending increases for policing (since 2018/19), criminal courts (since 2017/18) and prisons (since 2016/17) have not brought these services back to real spending levels seen in 2009/10 despite the explosion of digital crimes, growth in court backlogs and prisons operating near capacity. In the NHS, hospitals and general practice spending increased over the past decade but did not keep pace with rising demand.¹⁵ Overall school funding increased, but until 2021/22 was still below 2010/11 levels on a per-pupil basis. Meanwhile, local authority neighbourhood services have been cut back as budgets have been squeezed by central government grant cuts and increased spending on statutory services such as adult and children’s social care.¹⁶

* The Public Accounts Committee critiqued the level of fraud and error in pandemic spending, *COVID-19 cost tracker update: Thirty-eighth report of session 2021–22* (HC 640), The Stationery Office, 2022. <https://committees.parliament.uk/publications/8934/documents/152365/default>. The NAO has also identified issues with PPE contracting processes, *Investigation into the management of PPE contracts*, Session 2021–22, HC 1144, National Audit Office, 2022, www.nao.org.uk/wp-content/uploads/2022/03/Investigation-into-the-management-of-PPE-contracts.pdf, and *The Bounce Back Loan Scheme: an update*, Session 2021–22, HC 861, National Audit Office, 2021, www.nao.org.uk/wp-content/uploads/2021/12/The-Bounce-Back-Loan-Scheme-an-update.pdf

Figure 0.3 Change in public services spending since 2009/10 (real terms)



Source: Institute for Government analysis of government spending data, supported by CIPFA. Notes: Full details on data sources are provided in the Methodology chapter; the data series for criminal courts starts in 2010/11 as 2009/10 figures are unavailable.

Higher costs are squeezing budgets

Funding settlements for 2022/23 will struggle to cover ongoing higher public service costs despite the threat from Covid reducing. Some services have become more expensive to deliver and these costs are unlikely to fully return to pre-pandemic levels soon. The NHS is worst affected. Hospitals, for example, continue to incur costs associated with enhanced infection control measures, which may increase in response to future variants and winter case surges. Such measures also reduce the availability of beds, hampering the NHS's ability to clear backlogs and meet acute demand. Without sustained funding to address these ongoing costs or measures to reduce demand, public service providers will face a difficult decision as to whether to let quality standards slip or to reduce the scope of service they provide.

Furthermore, the inflationary pressures affecting households are also having some impact on public services. In 2019/20 around £1.4bn was spent on electricity, gas and oil by health, education, defence, prison and probation services combined. A further £200m was spent on fuel and £1.8bn was spent on food and catering by those same services.¹⁷ Prices for these goods and services have risen fast; even accounting for the government's six-month intervention to cap prices for businesses and public services, energy costs will have more than doubled since early 2021. However, the impact on public services is not as severe as on households. Energy costs account for 11% of household spending among the poorest tenth of households (and 4% among the richest tenth)¹⁸ but account for less than 1% of spending on the public services analysed by the ONS.¹⁹

Instead, the biggest cost pressures for public services are on staff, which accounts for over half of budgets in most of the services we assess. We analyse the impact of higher-than-expected pay awards in the context of the cost of living crisis below.

Demand

Covid has created substantial uncertainty about future demand for services

In some areas, service demands are higher than before the pandemic, adding pressure to already stretched systems. For example, GPs are delivering 5% more appointments than previously yet there is evidence that this is insufficient to meet demand, with patients struggling to book appointments.²⁰

In other service areas, demand fell significantly during the pandemic. In the NHS, it has been estimated that 7.6 million fewer people joined a hospital waiting list than would be expected in the first 18 months of the crisis.²¹ In adult social care 2.4% fewer over-65s requested to access care services between 2019/20 and 2020/21²² and evidence suggests up to 4.5 million more people provided unpaid care during the pandemic.²³ While some of these issues may have been resolved without the involvement of public services, others could have deteriorated, requiring greater support in the future – for example, some medical conditions if left untreated will require more complex interventions at a later stage.

The lower-than-expected increase in demand poses complex questions to public service providers as to whether and where this 'missing' demand will later materialise. To date, fewer people have been added to the elective waiting list than might have been expected, given reduced access to care during the pandemic, but it is unclear whether this is simply a consequence of bottlenecks elsewhere in the system. For example, GP referrals are still below pre-pandemic levels, despite them operating at capacity, and the NHS is unable to quantify the number of people who aren't getting general practice appointments.*

The same is true of demand for children's social care. Referrals fell by 7% between 2019/20 and 2020/21 but there was a 23% increase in calls to the NSPCC over the same period.²⁴ This suggests an increase in the number of children needing support, but this has not subsequently resulted in a surge in demand for children's social care services – and it is uncertain whether this will be seen at a later date. However, there is evidence that the complexity of children's needs has increased, leading to increased workloads even as caseloads stabilise.²⁵

Equally, it is unclear what additional demand might arise from the 2 million people experiencing long Covid.²⁶ Given the huge pressure that public services are already under, it would be potentially catastrophic if the 'missing' demand noted above appeared, not least given the possible impact that the winter flu season or further upticks in Covid might have. Government needs a clearer understanding of the potential impacts of these unmet or as yet unidentified needs to better ensure an appropriate service level for users and to plan how to manage and ideally reduce these higher demand levels over the medium term.

Wider demographic trends will drive increased demand for most services

Services also face increased demand from demographic trends, particularly the ageing population. Interim ONS population projections show the number of people aged 85 or older will increase from 1.7 million in 2020 (2.5% of the UK population) to 3.1 million by 2045 (3.1%).²⁷ This will affect some services more than others. These changes have been long expected yet it remains unclear whether sufficient funding plans are in place to adequately respond.

In each service, we have projected how demand is likely to change over the current spending review period (2022/23 to 2024/25).** These projections are uncertain and will be influenced by policy and behavioural changes, but illustrate the scale of increase in demand that services are likely to face (for example, how many patients GPs will need to see and how many schoolchildren will need to be taught).

We project that demand will continue to rise at least as fast as population growth in almost all services. We expect demand to grow fastest for health and adult social care (6.4%, 4.2% and 5.3% for hospitals, GPs and adult social care respectively between 2021/22 and 2024/25) as demographic pressures continue to bite; and in courts and

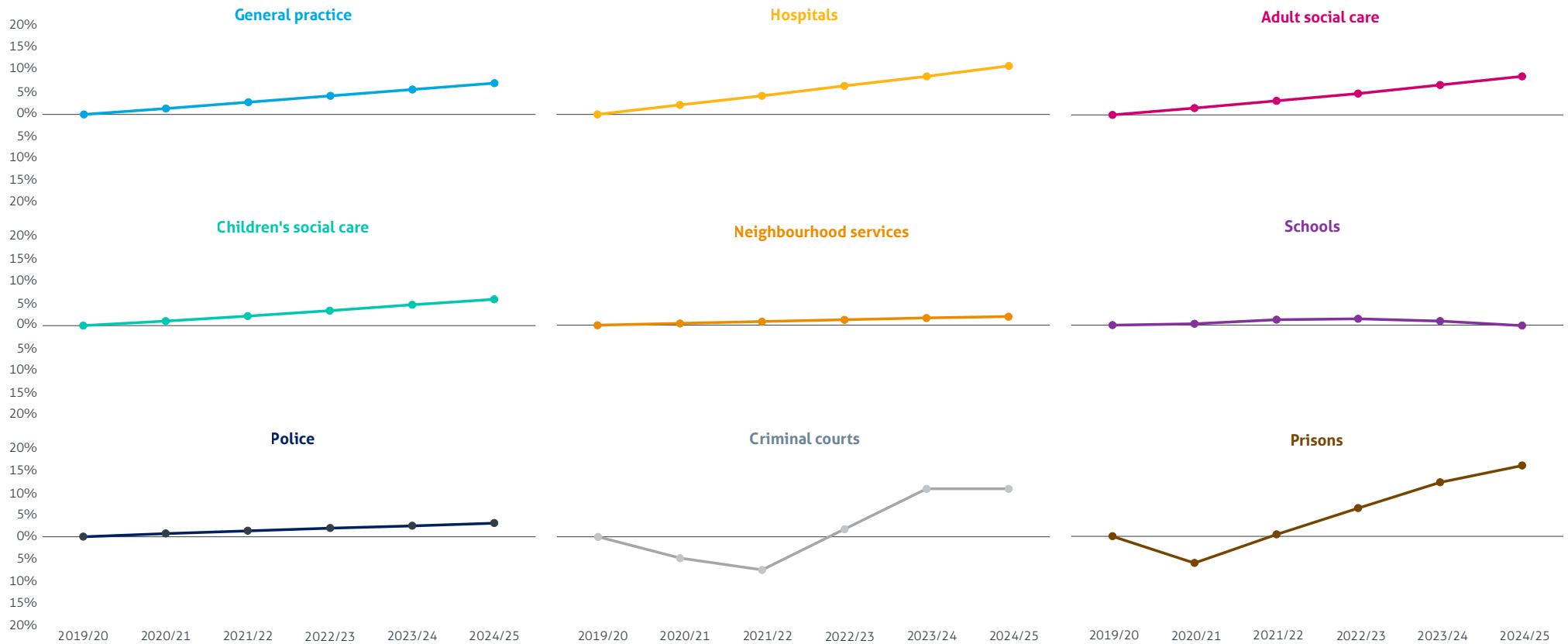
* There are some exceptions. For example, the increased number of cancer referrals in 2021/22 broadly offset the reduction seen in 2020/21, meaning that most of the 'missing' demand has likely been accounted for.

** Our approach differs by service. Full details are provided in a Methodology appendix and key details are provided in the notes below each figure.

prisons (19% and 15% respectively over the same period), with caseloads expected to increase as the Johnson government's 2019 pledge to recruit an extra 20,000 police officers translates into more charges – though this again is uncertain.

The main exception to this is schools, where a 'demographic dip' means that the number of school-age children was forecast to peak in 2022 and then decline for the next decade. In theory, this could also mean reduced demand for children's social care, but the overall number of children alone is a poor proxy for demand on these services due to the variety of factors that determine whether children require support from local authorities.

Figure 0.4 Change in public services demand since 2019/20, actual and projected



Source: Institute for Government analysis of government data, supported by CIPFA. Notes: Demand is indexed at 100 in 2019/20 – figures above 100 correspond to an increase in demand, figures below 100 correspond to a decrease; we project future demand for different services in different ways, see Methodology for full details.

Staffing

Some public services are struggling to fill empty posts

Staff recruitment and retention is one of the biggest problems facing public services, with the situation likely to get worse in some over the next year. In the criminal courts, a combination of stressful working conditions and low pay have contributed to falling barrister numbers. This in turn has hampered efforts to increase the number of judges, largely recruited from the ranks of barristers. In the NHS, there is currently a shortage of 12,000 hospital doctors and 50,000 nurses and midwives in England.²⁸

In adult social care, the workforce shrunk in 2021/22 due to factors such as difficult workloads during the pandemic, reductions in the pool of workers as a result of Brexit, and wages falling behind other sectors, including the NHS. In children's social care, recent workforce surveys suggest increasing turnover may be linked to similar market conditions.

Teacher recruitment was initially boosted by the pandemic, as has been observed at other times of crisis, but the number of trainees fell over the past year. As a result, the government is now back in the position it has been in for much of the past decade, struggling to recruit and retain enough teachers.

Recruitment and retention difficulties have led to high vacancy rates. In adult social care, despite falling in the first year of the pandemic, the vacancy rate rose in 2021/22, to 10.7%.²⁹ Likewise, vacancy rates in NHS providers initially fell but have recently risen again, with total vacancies reaching 9.7% in June 2022 – the highest level since at least June 2018, when this time series started.³⁰ Unfilled posts contribute to a greater use of agency workers, who come at additional costs* and tend not to be as effective as permanent staff as they must adapt to new teams and roles.

Covid-related absences have contributed to these pressures. In prisons, higher levels of staff sickness have made it harder to safely lift pandemic restrictions, with the result that prisoners are forced to spend more time in their cells with less access to work, education and training than previously, harming both their wellbeing and prospects. The NHS too continues to suffer from many staff falling ill to Covid and other respiratory problems such as colds and flu. The overall average absence rate for NHS staff rose to 5.5% in the 12 months to April 2022, a full percentage point higher than in the 12 months to April 2021³¹ – equivalent to 30,000 extra staff per month absent from the workforce. These pressures will not go away and may get worse as winter approaches. Lastly, when large numbers of staff fall ill, the workload of other staff increases, which may have contributed to noted staff burn-out across health and social care settings.

* NHS England has sought to reduce the use of agency staff and agency expenditure is one of the oversight metrics included in the NHS Oversight Framework for 2022/23.

In other services, political drive has contributed to higher recruitment figures

Targeted recruitment programmes in policing and among GPs have led to staffing increases in these areas. The number of police officers is up by almost 5% in 2020/21 compared to 2019/20 due to the Johnson government's target to add 20,000 more officers by March 2023³² – though figures still stand below 2010/11 levels and recent data shows the government has fallen behind on its 2023 target. Likewise, there are also 2.7% more GPs (including trainees, which offsets the decline in fully qualified GPs) in 2021/22 compared with 2020/21, linked to a government recruitment goal – though the government again looks likely to miss its target to deliver an extra 6,000 full-time equivalent GPs by 2024.

Higher overall staff numbers mask specialist staffing gaps and lack of workforce experience

The picture beyond these increasing headline recruitment figures is more nuanced, however. In the case of the NHS, despite increasing GP staffing, recruitment is still well below demand. This is the result of a decade of underinvestment in the GP workforce that the government is now hoping to reverse with a recruitment drive as part of the NHS Long Term Plan. It's also unclear how the increase in numbers of part-time GPs will affect total hours worked by GPs, as many part-time GPs often end up working beyond their contracted hours. Additionally, public services face specialist staffing gaps; police forces have chronic shortfalls in fraud specialists and schools face shortages of physics, languages and computing teachers, among others. These specialist shortfalls lead to reduced services and lower public service capacity.

Where staff levels are increasing, any influx in new and as such inexperienced recruits must be well managed. In policing, new entrants place an operational burden on other officers to train recruits,³³ and the shortcomings of a young and inexperienced workforce was one of the reasons the Metropolitan Police was put under special measures in 2022.³⁴ In children's social care, up to 60% of social workers in service at local authorities in 2021/22 had less than five years' experience³⁵ – a concern given that a 2022 government-commissioned report stressed the importance of experienced, knowledgeable and skilled workers in the sector.³⁶ In primary care, the government is on track to meet its target to recruit an additional 26,000 direct patient care (DPC) staff by March 2024, with the aim of freeing up GP time.³⁷ However, there is evidence that primary care networks are struggling to integrate DPC staff³⁸ and that GP workloads have increased as they spend more time managing a large workforce.³⁹

Similarly, in prisons, more experienced officers tend to be better at de-escalating potentially violent situations. But here, too, high levels of staff turnover mean that more than a fifth of prison officers have been in post for less than two years.

Civil service headcount cuts and strikes will exacerbate staffing problems

During the Tory leadership contest, Liz Truss's campaign endorsed the outgoing Johnson government's ambitions to reduce the civil service back to 2016 levels – though recent reporting suggests this target is being reviewed.⁴⁰ If implemented, this would mean approximately 90,000 fewer civil servants, which would be achieved through a range of measures including a recruitment freeze.⁴¹ As civil servants, both prison officers and courts staff may be subject to the 20% reduction. Prisons are already struggling to operate effectively with their current workforce and it is hard to see how they can safely house the projected increase in the prison population without more prison officers. Similarly, a reduction in court staff will further hamper efforts to reduce the courts backlog.

Worsening economic conditions, alongside long-standing below-inflation pay settlements, make strikes in key public services more likely. The pay settlements announced in July 2022 were largely rejected by unions, with the exception of the Police Federation. Many health care unions – including the Royal College of Nursing, the BMA and UNISON – are balloting members on possible strikes. Teachers' unions such as the NEU, NAHT and NASUWT are also consulting members on future action. In the justice system, criminal barristers voted for increasingly severe strike action, starting with day-long strikes in June,⁴² then alternate weeks from August,⁴³ and finally an indefinite strike that began on 5 September.⁴⁴

The government faces difficult decisions. Strikes will disrupt both service delivery and efforts to reduce pandemic backlogs. It has accepted the NHS Pay Review Bodies' recommendations⁴⁵ to increase the NHS wage bill by approximately £2bn⁴⁶ – around 4.6%⁴⁷ – in 2022/23 but is not funding this. As such the NHS will have to find the money from existing budgets as set in the 2021 spending review settlement.⁴⁸ This is likely to necessitate cuts elsewhere in the service. In the criminal courts, Brandon Lewis, the new justice secretary, made a revised offer, worth £54m more, which brought the criminal barristers' strike to an end in October.⁴⁹

Pay offers are higher than expected, eating into budget increases this year

While pay offers have been – without exception – below inflation, they have also been above what was expected when the spending review was agreed in October 2021. Pay review bodies have now reported and the government has responded, in most cases accepting the bodies' recommendations. For 2022/23, pay increases in our nine services range from 3% in courts to 8.5% in prisons. Some workers in these services have been awarded larger increases than this – for example, early-career teachers – though these are offset by smaller increases elsewhere. Table 2 lays out the average awards.

Across our public services we estimate that the total cost of pay awards in 2022/23 will be £3.3bn more than the 2–3% increase anticipated by the spending review. Even this understates the effect of pay pressure in the public sector because many local government services are contracted out and suppliers will be experiencing pay pressures that they will pass on to local authorities.

Despite this, in most services pay is still increasing less quickly than private sector wages, which the Bank of England expects will increase by 5.25% in 2022. This means that despite pay increases being beyond what was expected, they could nonetheless have a negative impact on retention as other options in the private sector look relatively more attractive. Increasing pay in line with private sector wages would cost an additional £440m.

The pressures on budgets are reduced a little by the reversal of the health and social care levy, announced in the former chancellor's September 'mini-budget', as the levy imposed costs on public services as employers. But the effect of higher basic pay increases is much larger, as the levy was only a cost to employers of 1.25% of salaries above the tax threshold.

Table 0.2 **Cost of 2022/23 public sector pay awards**

Service	2022/23 pay award	Extra cost relative to 2.5% increase	Extra cost if increase pay in line with private sector wages
General practice	4.6%	£126m	£39m
Hospitals	4.6%	£1,438m	£444m
Adult social care	5.0%	£81m	£4m
Schools*	5.4%	£1,165m	-£60m
Children's social care	5.0%	£88m	£4m
Neighbourhood services	5.0%	£27m	£3m
Police	5.0%	£295m	£29m
Courts	Staff: 2.8% Judges: 3.0%	£5m	£32m
Prisons	8.5%	£95m	-£51m

Source: Institute for Government analysis of various public sector pay review body reports and annual reports, supported by CIPFA. Notes: * = for schools, these figures refer to the 2021–22 academic year rather than the financial year; for adult and children's social care and neighbourhood services we only include staff costs incurred directly by local authorities and so subject to public sector pay deals; in practice, the pressure on budgets arising from pay will be much higher in these services because outsourced providers of social care and neighbourhood services will demand higher unit rates from local authorities; see Methodology for further details.

Higher inflation in the economy as a whole, on top of higher pay awards, means that what was originally a very generous spending review settlement in October 2021 now looks much less so. In October 2021, spending was expected to increase by over 7.6% on average across our services in 2022/23 in real terms. Taking into account the latest projections for economy-wide inflation from the OECD, we now project that the spending power of our services will in fact increase by only 4.1%.

This is still a substantial real-terms increase for one year, but may store up problems for future years. Most of the spending increases planned in the 2021 spending review settlement were front-loaded, with big increases in 2022/23 but barely any in the subsequent two years. Again using OECD projections, we predict that on average our services will see budgets increase by 1.5% per year over the spending review period as a whole compared with a planned 3.4%. Even this could understate the costs facing public services as energy prices – largely excluded from calculations of the GDP deflator – will still affect public service providers even though a relatively small share of their budgets is spent on energy.

Current spending settlements are now unlikely to be sufficient

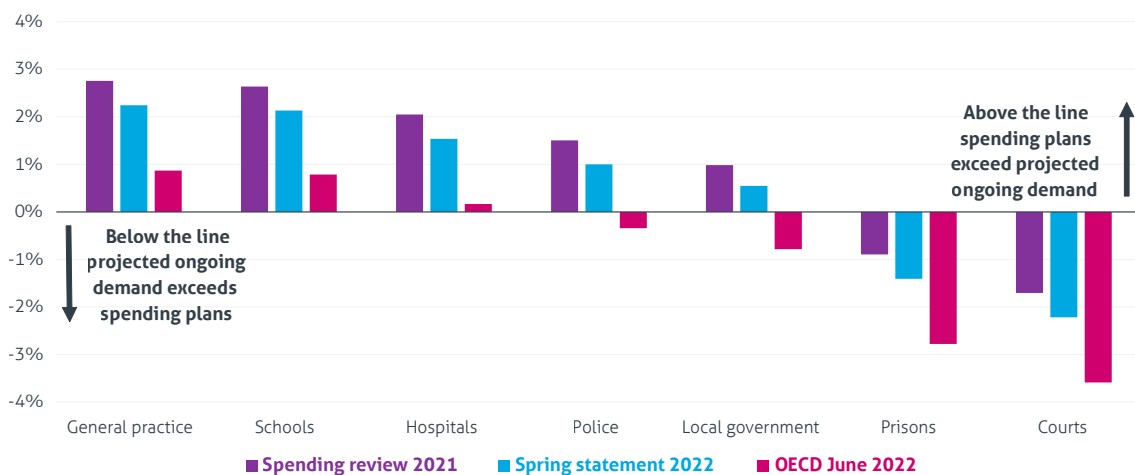
As a result of these cost increases, the 2021 spending review settlement is now unlikely to be sufficient to meet growing demands and deal with the aftermath of the pandemic in most services. Spending per pupil will increase in schools, but not by enough to recover lost learning since 2020. Hospital and general practice spending may just be sufficient to meet new demographic demand but not to address all of the 'missing' demand, should it materialise, or to enable a big enough increase in activity to unwind Covid backlogs.

In combination, the spending settlement for local government is no longer sufficient to meet demand in adult social care, children's social care and neighbourhood services. It is the former that accounts for the highest share of the budget and where demand is increasing most quickly. Even this analysis understates the squeeze on local authorities due to the impact that the extra demands on adult social care services, due to government reforms, will have on overall local authority finances. And the government's projections of local government spending power are predicated on council tax increases of 3% per year, which may prove politically unpopular and so difficult to deliver given the squeeze on household incomes.*

In prisons and courts, new demand is set to exceed even generous spending settlements. Even in the police, budget increases over the next few years will not exceed demand, but this does mask big increases in the budget since 2019/20, which means this is the only service where we judge that spending is sufficient to return performance to pre-pandemic levels.

* This policy is discussed in more detail in the Adult social care chapter.

Figure 0.5 **Difference between average annual real terms increase in services' budgets and projected increase in demand between 2021/22 and 2024/25 under different inflation scenarios**



Source: Institute for Government analysis of government data, supported by CIPFA. Notes: Ongoing demand only captures the impact of new demand, for example due to demographic changes, and does not include additional effects due to unmet demand during the pandemic; as a result, a spending settlement that exceeds projected demand is not necessarily sufficient to maintain service quality at pre-pandemic levels; local government covers adult social care, children’s social care and neighbourhood services; see Methodology for further details.

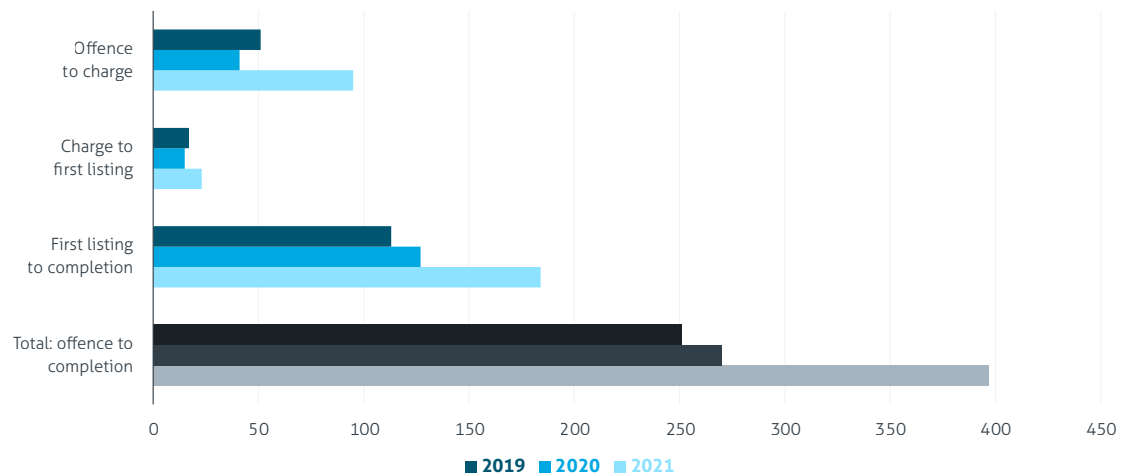
Backlogs

Many public services are still dealing with backlogs that grew during the pandemic. The small increase in spending power outlined above will not be enough to substantially reduce these backlogs and so return performance to pre-pandemic levels.

Backlogs are most apparent in hospitals and courts, while the lost learning in schools also constitutes a ‘backlog’ of teaching that will need to be compensated for if the affected cohorts of students are to reach expected attainment levels. In other services, such as children’s social care, there was temporarily lower activity during 2020 and early 2021, which could materialise into extra demand going forwards, but the data so far does not show that this has happened.

Longer waiting times are a problem in and of themselves because people cannot access services quickly. But in many cases longer waiting times will also lead to worse outcomes. For example, there has been a continued decrease in the share of urgent cancer referrals seen within two months, meaning some patients’ condition may have worsened by the time they are treated. In the justice system, too, longer waiting times mean that many victims may not support a prosecution when a resolution could be years away and, when cases are eventually heard, recollections of events many years before might be unreliable, making it harder for justice to be served. Waiting times have increased both before the case even reaches court (the time between the offence and a charge) and – more substantially – once a case is in the court system.

Figure 0.6 **Average justice system waiting times in days, 2019/20–2021/22**



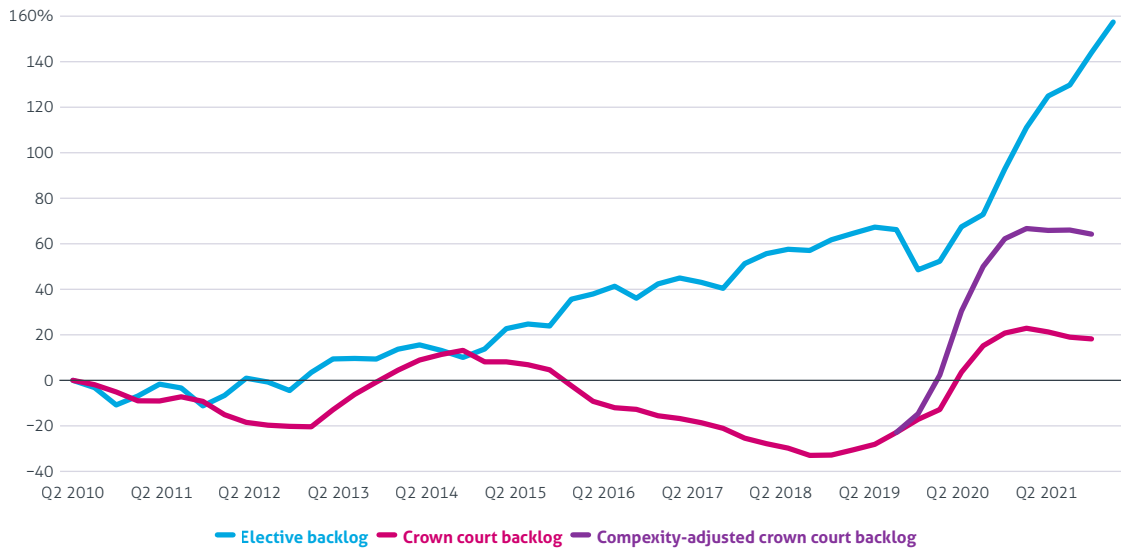
Source: Institute for Government analysis of government waiting list data, supported by CIPFA. Notes: Figures are medians and individual components may not sum to the overall total. See Methodology for further details.

Backlogs were growing before the pandemic but were badly exacerbated by it

In both hospitals and courts, measured backlogs are at historically high levels. Waiting lists for elective treatments stood at over 7 million people as of August 2022, the highest on record, while approximately 461,000 people were waiting six weeks or more for diagnostic tests – down from a peak of almost 573,000 in May 2020 but much higher than the 86,000 in March 2020. In the crown court, where the most serious cases are heard, the backlog stood at 59,700 in June 2022, slightly below the peak of more than 60,000 in June 2021 but higher than at any point since at least 2000.

These backlogs are not just an effect of the pandemic. In both services, backlogs were already increasing before this. Waiting lists for elective procedures rose from 2.3 million in February 2010 to 4.4 million in February 2020. In the same time period, the number of people waiting more than six weeks for a diagnostic test increased from 4,000 to 30,000. Meanwhile the crown court backlog increased from a low of 33,000 in March 2019 to almost 40,000 at the onset of the pandemic. But the scale of disruption wrought by the pandemic led to a serious worsening of these backlogs. Almost all elective procedures and jury trials were put on hold for months. Crown court backlogs increased by 43.2% between March 2020 and December 2021 while the NHS elective waiting list increased 54.6% over the same period.

Figure 0.7 **Change in elective care and crown court backlogs since Q2 2010**



Source: Institute for Government analysis of government backlog data, supported by CIPFA. Notes: See Methodology for further details.

The true size of backlogs is not captured in the headline statistics

Even the enormous backlogs currently on record do not capture the full scale of the problem. The best measure we have for 'backlogs' in the health system is published waiting lists. But in practice there will be others in need of treatment who are not yet on the waiting list, perhaps because they have not yet been referred by their GP or are struggling to get an appointment in the first place.

GP referrals fell substantially during the pandemic. This is partly because the NHS made a concerted effort to reduce non-urgent elective care in hospitals at the start of the pandemic, which resulted in 5.3 million (or 32%) fewer completed elective pathways in 2020/21 compared to 2019/20. It also extended the rollout of 'advice and guidance' (A&G) – an innovation that has had the effect of lowering the referral rate from primary to secondary care. Finally, several interviewees told us that hospitals are rejecting referrals at a greater rate than before the pandemic.

This may partly explain why, though long, waiting lists have not increased by more. In the case of the elective backlog, the Institute for Fiscal Studies estimated that 7.6 million fewer people joined a waiting list for hospital care during the pandemic than they would have expected.⁵⁰ While some of those people may no longer require care, it is likely that others will come forward and that the flow on to waiting lists has merely been slowed by the difficulty of accessing health services, rather than cut down as a result of falling demand. As a result, the 'true' increase in the number of people waiting for treatment is likely to be higher still than the 2 million person increase the elective waiting lists suggest.

In the crown court, every outstanding case is recorded in the same way whether or not it is an appeal, a decision for sentencing, a case that requires a jury trial or a case that will not. But some cases will take much more time to process than others. Jury trials (required only when defendants plead not guilty) account for less than 20% of all

cases in the crown court but take up over 75% of court time. During the pandemic, it was jury trials that were most badly affected because they require so many people to be in the courtroom and they could not be heard online. This means that the backlog now disproportionately contains these lengthier cases, which will take longer to process. We calculate that, after adjusting for the composition of the backlog, on a like-for-like basis the backlog has effectively doubled to more than 80,000 cases, and barely begun to fall.

While the headline statistics for these backlogs may not capture the true scale of unmet need, they do at least provide a starting point. In other services, and schools in particular, there is no regular gauge on progress towards recovering and reversing the impacts of lost provision during the pandemic. A series of studies has shown conclusively that disruption to in-person teaching meant pupils fell behind in their learning, and that this was especially true for children from disadvantaged backgrounds.⁵¹ The decline in Key Stage 2 (age 11) performance in 2022 gives one measure of the impact of lost learning, but a lack of consistent external assessments makes it much harder to track the impact on older pupils.

The government's ambitions are unlikely to be met given the resources available...

The government has set out plans to tackle backlogs over the spending review period. But in each case it will be difficult to achieve these plans given current resourcing plans, even where they are relatively unambitious.

The government's approach to the crown court falls squarely in the 'unambitious' category. Its stated ambition is to reduce the backlog to 53,000 cases by November 2024. This would mean that the backlog would have fallen by only 7,000 cases from its peak and would still be 14,000 cases above pre-Covid levels. Before the announcement of barrister strikes, the government was on track to meet this with room to spare – the backlog fell by 2,000 cases in the six months to March 2022. But even then the number of cases outstanding fell only because the inflow of cases into courts (which depend on police activity) continues to fall below expectations. The courts are still less efficient than they were before the pandemic, with many trials being rearranged due to Covid-related absences. So, if case receipts pick up as expected, the courts will struggle to make any inroads into the backlog at all.

In hospitals, the NHS very nearly met the first, though least ambitious, of its three targets in the backlog delivery plan: eliminating waits of more than two years by July 2022. But its subsequent targets – eliminating 18-month and one-year waits by April 2023 and May 2025 respectively – will be much harder to meet and crucially rely on hospitals being able to operate at 130% of pre-pandemic activity levels, despite currently operating at roughly 95%. Given that hospitals still have some enhanced infection control measures in place, reducing their efficiency, this will be especially difficult to achieve.

On schools, while the 'backlog' is less easily quantified the government has certainly not shown much ambition in its funding, committing only £5bn to education catch-up between 2020/21 and 2023/24. This is one third of the £15bn that the government's education recovery commissioner recommended in 2021, suggesting

the current programme is unlikely to be sufficient to reverse the detrimental impact of the pandemic. Furthermore, the National Tutoring Programme, the single largest programme dedicated to education catch-up, got off to a rocky start. In March 2022, funding was transferred from two strands of the scheme administered by recruiting firm Randstad, to a strand under which schools are able to source their own tutors.

... and extra funding alone will not be sufficient to clear all backlogs

One of the reasons backlogs are so difficult to tackle – and so the government’s plans are so difficult to meet – is that they are not problems that can be solved with one-off funding injections. Instead, other problems mean that there is only so much difference that short-term extra spending would make. For example, in the courts, the Ministry of Justice has once again provided funding for ‘unlimited sitting days’.* But limits elsewhere – principally a shortage of judges and barristers – mean that despite a supposed blank cheque the number of cases dealt with this financial year is unlikely to be much higher than last.

As Table 3 highlights, similar workforce constraints apply in other services with backlogs. These are the types of restrictions that can be lifted in the longer term – for example, by training more doctors or substantially increasing pay– but not ones that can be solved overnight.

Table 0.3 **Public sector backlogs and constraints on attempts to reduce them**

Service	Nature of backlog or unmet need	Key constraints on faster backlog reductions
General practice	Missed appointments during pandemic and difficulty accessing appointments now	Shortage of GPs
Hospitals	People waiting longer for A&E, elective care and cancer treatment	Shortage of beds and staff, including in social care, and continued need to deal with Covid outbreaks/cases
Criminal courts	Cases waiting to be heard	Shortage of judges and barristers
Schools	Lost learning during pandemic	Inadequate funding
Children’s social care	Missed referrals during pandemic	N/A. Missed referrals during pandemic do not appear to have resulted in increased demand so far but referrals data for 2021/22 has not yet been published
Adult social care	People waiting for assessments and care	Inadequate funding and shortage of staff

* Days in which there is no financial restriction on the number of court sittings that can occur.

Neighbourhood services	Planning applications and food safety inspection backlogs	Inadequate funding and shortage of staff
Prisons	Staff training and prisoner access to services	Shortage of staff
Police	Low charging rates	Volume of digital evidence and shortage of investigative staff

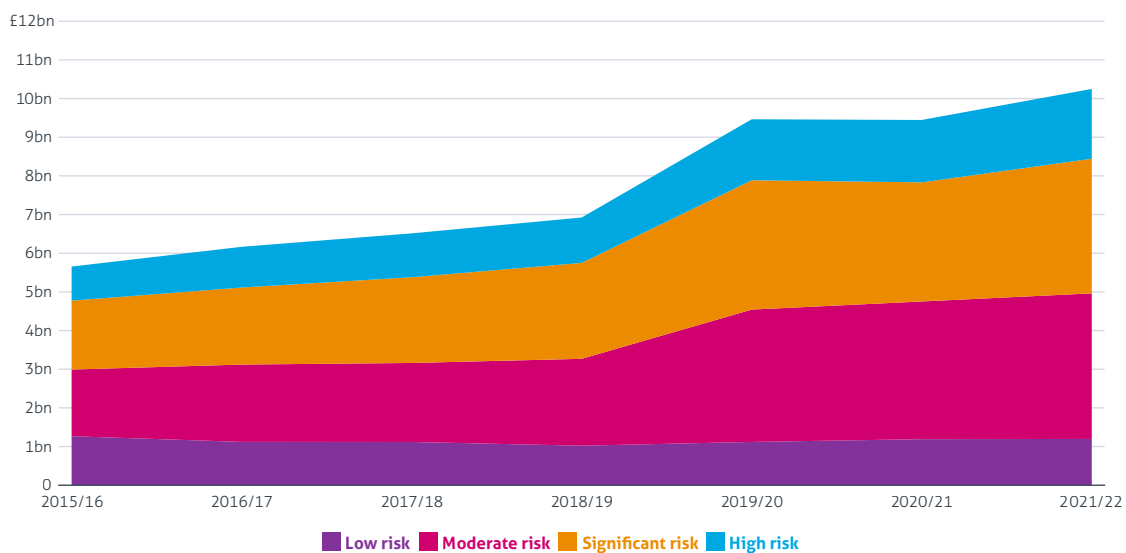
Source: Institute for Government analysis, supported by CIPFA.

Maintenance backlogs are growing, further limiting the capacity of services

A sizeable maintenance backlog totalling almost £23.7bn has accumulated across the NHS, schools, courts and prisons. But deferring necessary upkeep costs to the future is a false economy as smaller, earlier fixes are cheaper than the cost of bringing dilapidated assets back to standard.

The latest assessment of the schools estate, published in 2021, identified an average of £311,000 repairs for each primary school and £1.6m for each secondary school – totalling £11.2bn.⁵² Similarly, in 2021/22 the NHS hospital estate faced a maintenance backlog standing of £10.2bn, some 8.5% higher than a year earlier.⁵³ This followed substantial cuts to NHS capital spending from 2010 onwards.⁵⁴ A poorly maintained estate is detrimental to hospital productivity – central heating or air conditioning failures might force hospitals to close wards, or faulty equipment may fail during procedures.

Figure 0.8 **Cost to eradicate the hospital estate maintenance backlog, 2015/16–2021/22 (2021/22 prices)**



Source: Institute for Government analysis of NHS Digital, 'Estates Returns Information Collection - dataset for ERIC 2020/21, report version 2', Table 10, supported by CIPFA.

This problem is not restricted to schools and hospitals. In prisons, the backlog of highest priority major capital works is currently estimated to be around £1.3bn. These include projects to address significant health and safety or fire safety risks, and/or critical risk to capacity. The backlog has been increasing by around £225m per annum in recent years, from £900m in 2019/20.⁵⁵ In courts, the former chief executive of HMCTS estimated in March 2022 that the courts maintenance backlog stood at £1bn but also cautioned that improvements to courtrooms would see them taken out of action, potentially increasing the backlog of cases.⁵⁶

If efforts are not made to bring these assets back to good working standards, services may deteriorate. Teachers, doctors, nurses and other public sector workers require adequate space and equipment to carry out their roles and a dilapidated estate may bake inefficiencies into the system at a time when productivity gains are required to tackle backlogs and unmet need. The Treasury and spending departments should carefully consider these risks if they plan to deplete already tight capital budgets, as happened between 2010 and 2020.⁵⁷

Performance

The performance of most public services has declined since the start of the pandemic

Unsurprisingly, given the disruption caused by Covid, the scope or quality of all nine services that we assess has deteriorated over the past two years. But this cannot be put down solely to the pandemic and in most cases continued the downward trend seen since 2010.

The worst affected services are hospitals, criminal courts and prisons. All three have been unable to conduct business as usual for large periods of the pandemic, leading to substantial growth in backlogs and waiting times. The real size of the crown court backlog, taking into account the complexity of cases, has barely started to fall, while the elective treatment backlog is likely to continue growing for years to come. This means the public must wait far longer to access care or see justice served. Meanwhile, large parts of the prison estate remain heavily restricted, with prisoners spending longer in their cells with less access to rehabilitative activity.

Key performance measures for other services have also declined. The rate and number of police charges have continued to fall, while polling data shows public satisfaction and confidence in police has been severely dented by a series of high-profile scandals. Similarly, patient surveys show that many are finding it increasingly difficult to make GP appointments. In 2022, only 56.2% rated their experience of making an appointment as good or better, down from over 70% the previous year. Overall satisfaction with general practice fell from 83% to 72.4% over the same period.

The same trend can be seen in local authority delivered services, with many adult social care and neighbourhood services shrinking in scope or reducing levels of support. Meanwhile, schools have not been provided with sufficient resources to enable pupils to catch up on learning lost during the pandemic.

All this would have been more manageable had services been in good shape on the eve of the crisis. However, the decade of spending restraint from 2010 onwards had already resulted in longer waiting times, reduced access, rising public dissatisfaction, missed targets and other signs of diminishing standards. Prisons, general practice and hospitals had seen the most dramatic decline in performance over this period, but all services, with the sole exception of schools, entered the crisis performing worse than a decade previously.⁵⁸

Added to the slow pace of recovery from Covid, public services are poorly placed to weather future disruptions, be those heatwaves, winter flu, future Covid outbreaks or other emergencies. In particular, the NHS has struggled throughout 2022, even during the normally quieter summer months, with the elective backlog, A&E waits and ambulance response times all at record levels. The winter is likely to be even worse due to higher levels of flu and a possible Covid resurgence.

These problems will be exacerbated by the cost of living crisis. The NHS Confederation has issued a warning that high energy prices could create a “public health emergency” as people cut back on food and heating, putting further pressure on health and care services.⁵⁹ And the former chancellor, Kwasi Kwarteng, had previously highlighted that “the frequency and severity of health problems like flu, heart attacks and depression... have all been linked to cold homes”.⁶⁰ Government support to cut energy bills might reduce some of these impacts but energy bills will still be much higher than they were even a year ago and as prices more broadly exceed wage increases households will be looking for ways to save money.

Even without these problems, it is unlikely that any service, other than the police and possibly children’s social care, will perform better in 2025 than they did pre-crisis, and there is even less chance that they will reach the performance high watermark of 2010.

Limited data makes it harder to assess performance

The trend of worsening performance across most services is clear but the absence of critical data makes it harder to get the full picture. For example, the NHS does not collect information on the number of people who are *unable* to book GP appointments, making it impossible to accurately gauge the level of unmet need and the extent to which ‘missing’ demand from the pandemic is likely to reappear.

Similarly, the suspension of many inspection activities during the pandemic means that there is less publicly available information than usual on the performance of public services. From March 2020 to April 2021, the Care Quality Commission – the inspection body overseeing the NHS and adult social care – paused routine inspections and focused on areas of serious risk to the public.⁶¹ It later adopted a more risk-based approach in early 2021 before in December 2021 affirming it had no intention of returning to its regular inspection regime due to winter pressures and the Omicron variant.^{62,63} Similarly, Ofsted suspended routine inspections of schools and children’s social care services from March 2020, only resuming a full programme of inspections from September 2021 for schools and from April 2021 for children’s homes.^{64,65,66}

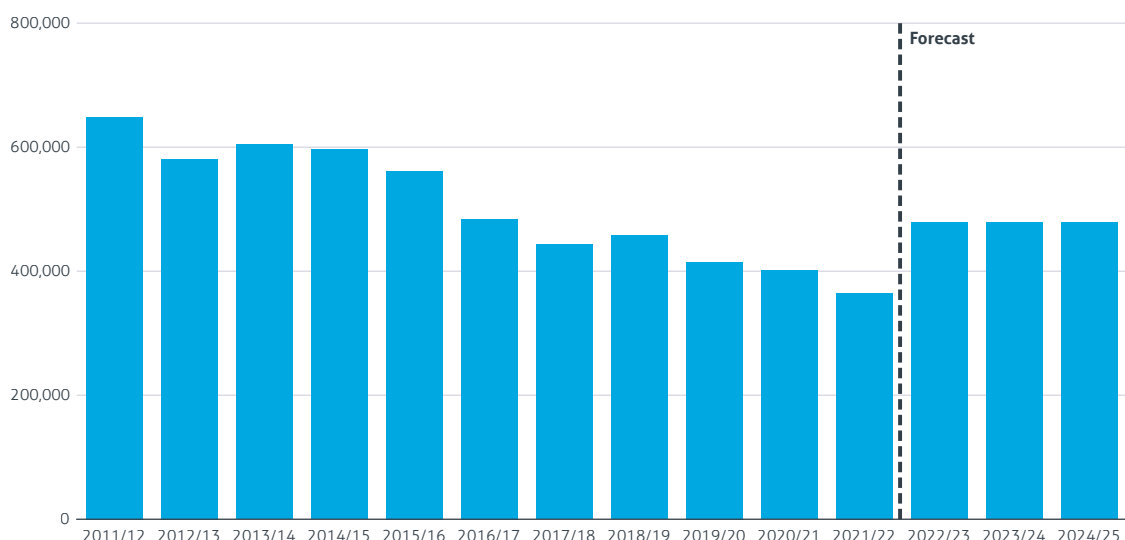
These were pragmatic decisions. It was important to design an appropriate, proportionate and safe inspection regime during the worst of the health crisis – but the result is that we lack a comprehensive picture of quality across all health care, adult social care, children’s social care and education settings. As inspection regimes return to normal we will gain an increasingly detailed picture of any decline in services. Though with CQC inspections changing due to the 2022 Health and Care Act, with new responsibilities across integrated care systems, the new normal may be different to pre-pandemic.

Fewer cases than anticipated are progressing through the criminal justice system

Even before the pandemic, the criminal justice system – which starts with the police and ends with prisons and probation – was due to undergo substantial change and pressures during the early 2020s. From 2014 onwards, the system was characterised by declining caseloads: fewer police charges, which in turn meant fewer court cases and a slower inflow into prisons. But this trend was expected to reverse following the government’s announcement that it would increase police officer numbers by 20,000 by 2023, returning the total to 2010 levels. The Institute for Government, among others, projected that this would lead to more cases being charged by the police, which in turn would lead to more demand for the criminal courts and, by extension, prisons. Both the 2019 spending round and the 2020 spending review included additional resources to help criminal courts and the Crown Prosecution Service manage this.

However, charging rates are yet to increase. The changing nature of crime and expansion of police responsibilities during the pandemic probably contributed to a 3.7% fall in the number of charges between 2019/20 and 2020/21⁶⁷ – but charges fell again in 2021/22, even as policing activity returned to normal patterns.⁶⁸

Figure 0.9 Charges by police, actual and forecast, 2011/12–2024/25



Source: Institute for Government analysis of policing data, supported by CIPFA. Notes: Full details on data sources are provided in the Methodology chapter; figures up to 2021/22 are presented in FTE terms, forecast figures from 2022/23 draw on headcount figures.

There are several possible explanations for this, each of which would have different implications for demand in courts and prisons going forwards. One is that investigations are under way but simply haven't got to court yet. If that is so, a low number of charges could be a one-year blip.

Others have pointed to where new police officers are deployed. New recruits tend to be placed in visible, front-line roles rather than filling the gap in, say, detectives that has been identified by the Police Federation, among others. While new officers can arrest people within a matter of weeks – as much of the training they receive is 'on the job' and a lot of routine crime is investigated by uniformed officers – they also require effective support and mentoring to learn the evidence standards needed for successful prosecutions. In short, more arrests on the street does not always mean more charges, and HM Inspectorate of Constabulary and Fire Services recently found the relative inexperience of new officers was contributing towards low charge rates even for volume crimes such as theft, robbery and burglary.⁶⁹

There has also been criticism from parliament about the way new officers have been allocated across forces – including the use of an outdated allocation formula, meaning some officers are being assigned to areas they aren't needed.⁷⁰ If this is the predominant reason for low charge rates, we should expect the trend of lower-than-expected charging rates to continue.

Finally, interviewees pointed to the growing complexity of crime as a countervailing force that means more police investigative time is not translating into more prosecutions. There are two facets to this trend. First, interviewees pointed to growing amounts of digital evidence – a trend we identified in 2020 as a big driver of declining charge rates.⁷¹ Second, police have been more focused on certain crimes – especially sexual assault – that tend to be more complex and take longer to investigate and which have led to very few successful prosecutions in the last few years.

If extra police officers do – as expected – reverse the decline in charges, both the courts and prisons will face substantial demand pressures. This is reflected in our demand projections for both services above. This will be difficult for the courts. As noted above, in the next couple of years the courts have little capacity to increase case processing because they are constrained by the availability of judges and barristers. And in 2021/22 there was evidence that the courts are still not operating as efficiently as before the pandemic, further limiting capacity.*

It then follows that, if courts could increase their throughput, prisons would also struggle. Before March 2020, prisons were almost at capacity but as the number of trials fell during the pandemic, so did the number of prisoners. The number of prisoners has now crept up over 80,000 again and the current estimate of usable operational prison capacity is just 82,899.

* For example, the vacation rate has increased in 2021/22. For further details see the Criminal courts chapter.

This is a long way short of the more than 95,000 places that the MoJ projects, based on growing police and court activity, will be needed by 2025. This gap could be bridged by the Johnson government's plans to build 20,000 additional prison places by the mid-2020s (of which around 3,100 are ready) but governments have struggled consistently in the past decade to meet similar aims.

Fewer patients than needed are passing through the health and care system

Like criminal justice, health and care is a system with interdependent services. Although hospitals receive the lion's share of funding (and political attention) it will not be possible to reduce waiting times for A&E, elective care or cancer treatment without sufficient community care and adult social care capacity to support this. And it will be harder for GPs to manage their caseloads unless they can refer patients to hospitals in a timely manner. Unfortunately, the system is currently performing worse than the sum of its parts, with problems in one service increasing demand in others.

It is hard to quantify demand for general practice because, as noted above, there is no data collected on the number of people who are unable to book appointments. However, in addition to underlying demand for primary care and that generated by Covid-related conditions, GPs are facing pressures created by the failure of a range of public services to support patients at the first time of asking or in the most appropriate setting. For instance, we heard that GPs now spend more time supporting patients with long-term conditions who might otherwise have been treated in community, secondary or adult social care.

What is certain is that GPs are referring fewer patients to hospitals both in comparison with pre-pandemic referral rates and in absolute terms. There are a number of reasons for this, the most important of which is NHS England guidance for GPs to liaise with secondary care colleagues to gain advice on whether a referral is the best course of action. However, even where referrals are made, hospitals are now more likely to reject them,^{72,73} pushing them to other parts of the system, including primary care, community care and adult social care. While these measures may help to reduce demand on hospitals, it will also increase the workload of GPs and other forms of community care, limiting their ability to meet unmet need in their areas.

In hospitals, problems are arising from all directions. At the height of the pandemic the number of diagnostic tests, outpatient appointments and referral-to-treatment times dropped substantially. Data from July 2022 shows activity for each has increased but is yet to return to pre-pandemic levels.

NHS capacity to accommodate more admissions is being limited by a high bed occupancy rate. A major contributory factor towards this is the 18.7% decline in the number of general and acute overnight beds from 274.4 beds per 100,000 people in 2010/11 to 223 per 100,000 at the end of 2021. High occupancy rates are also due to delays discharging patients. Thousands of patients a day who meet the criteria for discharge are unable to leave due to problems within the hospital system and insufficient social care capacity. This is driven by a number of factors: a lack of social workers employed by local authorities who carry out assessments for care, shortfalls in care worker staffing levels, and insufficient community care.

With 50,000 fewer workers employed in the adult social care workforce in 2021/22, the sector faces challenges to recruit and retain staff – a problem that is likely to increase as staff are attracted to better paid work elsewhere, including in the NHS. The government recognised the problem with delayed discharges in *Our plan for patients*⁷⁴ but the £500m fund announced is not new money and given its limits – both in terms of time and funding – is unlikely to make a long-term difference to the problem of delayed discharge.

While many patients who could be discharged are not, others are discharged earlier than they otherwise would have been due to bed and staff shortages, increasing demand on adult social care providers. According to the Association of Directors of Adult Social Services, these people “are sicker, have a high level of need than they would have had prior to Covid-19, meaning additional and more intensive support is required in the community and via local authority funded adult social care”.⁷⁵

Concerningly, there are also signs of a backlog in social care demand with more than 294,449 people awaiting assessment by social services as of April 2022,⁷⁶ up from approximately 70,000 people in September 2021.⁷⁷ Delayed assessments may feed back into NHS pressures if a lack of proper care packages and adjustments lead to more serious medical problems.

Increasing social care costs have put pressure on local neighbourhood service budgets

A decade of cuts to grant funding by central government forced councils to prioritise spending on some services to the detriment of others.⁷⁸ Between 2009/10 and 2019/20 there was a 63% reduction in local authority grants (in 2019/20 prices and factoring in business rates as a grant).⁷⁹ In response councils increased revenues from other sources including sales, fees and charges, and the ‘adult social care precept’ (introduced in 2015 to allow local authorities to raise additional council taxes to finance adult social care), but these have not alleviated pressure on council budgets.⁸⁰

Local authorities have a statutory responsibility to protect the welfare of children and for the wellbeing and safeguarding of adults,^{81,82} and the rising demand for social care has limited the available money for other services.⁸³ An ageing population has increased demands on adult social care, with the number of people aged 65 and over increasing by 22% between 2010 and 2020, alongside an increase of 21% in the over-85s over the same period.⁸⁴ However, demand from working-age adults has grown even faster, due to better health care improving the life expectancy of some people with disabilities and these adults being more likely to meet the means-test for support.⁸⁵

While the pandemic reduced referrals to children’s social care, the decade from 2009/10 to 2019/20 saw substantial increases in referrals, the number of protection plans, looked-after children and child assessments.⁸⁶ In addition, the nature of cases coming forward since the pandemic are reportedly more complex adding extra pressure to the system.⁸⁷

The impacts of these two trends – decreased funding and increased social care pressures – have varied across councils in England, with the most deprived areas receiving the largest grant cuts while also seeing the greatest increase in adult social care spending.⁸⁸ The local authority response has also varied in response to local spending priorities. Institute for Government analysis of council spending between 2009/10 and 2019/20 showed disproportionate cuts to housing services, planning and development services, and cultural and related services.⁸⁹

There has also been a shift in the types of services local authorities provide, with councils increasingly prioritising statutory and demand-led services at the expense of preventative and universal services.

The difficulty of managing increases to social care costs has not eased during the pandemic. Even though emergency Covid support assisted with some costs in the short term, growing underlying demand for social care will continue to constrain local government spending decisions.

Transformation

Some services have continued to make greater use of remote technology

Public services have made much greater use of technology in response to Covid, particularly to enable remote access when normal services were unable to operate. Despite the lifting of final lockdown restrictions in July 2021 and appeals from ministers to fully return to face-to-face work, many services, particularly prisons and the NHS, have continued to make greater use of remote technology than before the pandemic.

The Ministry of Justice has installed in-cell telephones in 31 prisons since March 2020, almost doubling the number with these facilities. On the eve of the pandemic, none had video calling available but all prisons had this technology installed by December 2020 and more than half a million video calls have been made since their introduction.⁹⁰ Improved access to telephone and video calling has enabled prisoners to keep in touch with their families and access training and education, despite restrictive lockdown regimes that have continued into 2022/23.

The NHS also continues to make much greater use of remote technology. In general practice, around a third of consultations still take place via telephone – below the peak of 47.8% in April 2020 but substantially above the February 2020 rate of 13.5%. There is less reliable data on the use of remote consultations in hospitals but the evidence available suggests these too remain above pre-pandemic levels. Hospitals are also using 'virtual wards', which enable clinicians to monitor patients remotely.

Other services still use remote technology but at a much-reduced level. Remote court hearings – both via video and telephone – were critical for allowing some activity to continue while courtrooms were closed. These are now used less frequently as lockdown restrictions have eased and generally just for short routine hearings, though this varies across the country.⁹¹ Interviewees told us that these hearings were no more efficient for courts, although they do save barristers time, and that in general they are not felt to be appropriate for more substantive hearings.

Similarly, in-person pupil attendance in schools has almost returned to pre-pandemic levels, with very little teaching now taking place remotely. However, some teachers and pupils are still making use of virtual learning materials. Oak National Academy – a repository of online lessons established in April 2020 – has been turned into a non-departmental public body designed to “support teachers in delivering excellent curriculum content as part of world class lessons”.⁹²

Remote technology appears unlikely to greatly improve efficiency or reduce backlogs

Despite the widespread use of technology during the pandemic, there are no robust and systematic evaluations of its impact on services or their users. What evidence there is suggests that the benefits are mixed, at best.

Remote technology has been used most effectively for relatively simple work, such as administrative court hearings or routine GP appointments. However, many public services and the backlogs they’ve built up are more complex and less transactional than this, benefiting greatly from face-to-face interaction between trained staff and the public. It is far easier, for example, for a doctor to take blood, listen to an intake of breath or assess a patient’s overall health in-person. And, as mentioned above, the crown court backlog is disproportionately comprised of jury trials, which cannot take place remotely.

Even where remote services are convenient for service users or some staff, it’s not clear that they are more efficient. In general practice, telephone appointments may be marginally shorter, but often require a follow up face-to-face appointment, rather than being dealt with first time.⁹³ Similarly, it does not appear that judges can hear more cases when doing so remotely.

Critically, there is also evidence that delivering services remotely actively reduces quality. For example, doctors are less likely to notice crucial symptoms⁹⁴ and social workers may miss signs of abuse if they don’t see children inside their homes.⁹⁵

Expanded use of remote technology will require evaluation and investment

The government has spoken in broad terms about the need for public services to make greater use of technology, notably in June when the then health secretary, Sajid Javid, described the NHS as a “Blockbuster health care system in the age of Netflix”.⁹⁶ If it wants to encourage more remote access to public services the government should first fill the extensive evidence gaps on the impact this would have on service efficiency and quality.

Doing so would also require substantial investment. Many remote services have been hampered by poor internet connections, outdated software, slow computers, inadequate telephony and a lack of user knowledge that may disproportionately impact some demographic groups. Although the 2021 spending review includes increased capital budgets, there is a risk that, as happened over the 2010s, money from these is transferred to meet day-to-day spending as budgets are squeezed over the next two years.⁹⁷

Recommendations

Public services face a difficult fiscal environment and will struggle to return performance to 2019/20 levels – which in most cases was worse than a decade earlier. Even if the Truss government sticks to 2021 spending review commitments, public services will have to absorb additional inflation costs and higher wage demands. Though it is expected that some form of cuts, relative to current plans, to public services will be announced in the upcoming 'medium-term fiscal plan'. With spending restraint likely in the short to medium term, government will need to focus resources through better planning, improved data systems and greater transparency about performance.

Improve public service workforce planning

The Conservatives won the 2019 election on a manifesto that included high-profile targets to recruit more doctors, nurses and police officers. Some progress has been made, particularly in the police (though officer numbers are still lower than in 2010), but most services continue to experience critical problems with recruitment and retention. Indeed, staff shortages are the main constraint on government plans to reduce backlogs and address unmet need.

Reduced vacancies and job security in the private sector contributed to improved retention and recruitment in most public services during the first year of the pandemic, but this did not last. It is likely to deteriorate further given public sector pay settlements will see wages rise somewhat slower than in the private sector, and substantially below inflation. Staff across all public services will be badly affected by the cost of living crisis. Combined with high workloads, levels of stress and job dissatisfaction, many are at crisis point.

- **The government should take immediate steps to ensure that there are enough to staff to enable services to cope with even higher demand this winter. But it also needs to tackle underlying problems, which will require effective workforce planning.**

Unfortunately, this has been a major weakness for successive governments. The Johnson government even rejected a modest amendment to the Health and Care Act 2022 to require government to publish regular reports on existing and anticipated workforce shortages.⁹⁸

- **The prime minister should commit to publishing regular workforce assessments, with plans for how shortages will be addressed, for all of the services covered in this publication.**

Publish detailed backlog recovery plans

Government plans for addressing backlogs and unmet need are inadequate. Its strategy for addressing the crown court backlog has not been updated in more than two years, with the target to reduce this to 53,000 cases coming from a single line in the 2021 spending review. The NHS elective recovery plan is a weightier document and was published this year but, in the absence of a proper NHS workforce plan, the measures included are unlikely to increase staff capacity sufficiently to deal with the scale of the problem at hand.⁹⁹

Sir Kevan Collins was appointed by the government to develop a plan for supporting pupils to catch up on lost learning. His comprehensive proposals would have cost £15bn but these were rejected by the government, which has so far committed only around £5bn to its catch-up response.

Failing to address backlogs is a false economy, leading to increased demand for public services and, in the case of lost learning, a less skilled workforce, with implications for economic growth and taxation.

- **The government should publish updated plans for how each service will tackle backlogs and unmet need, which include key milestones and assessments of the workforce and estate.**

Consider the system-wide impact of spending decisions

Government spends tens of billions of pounds every year on public services. But insufficient thought is given to how best to allocate that money between and within services. As noted above, services operate interdependently, with problems in one adding to demand in others. But spending is rarely considered in this way.

The starkest example is health and care. Despite adult social care being a crucial component of the system, and a key reason for delayed hospital discharges, spending increased by only 8% between 2009/10 and 2020/21, compared to 39% for hospitals and 41% for general practice over the same period.

Meanwhile, capital budgets were routinely raided over the past decade to meet day-to-day spending needs. In the NHS, for example, spending on equipment such as MRI scanners was cut 62.6% between 2013/14 and 2018/19.¹⁰⁰ This approach helped manage immediate crises, but has damaged the long-term productivity of services and contributed to worse service delivery and outcomes. Put simply, front-line staff will be able to process fewer patients or court cases, and will do so less well, if they are working with old equipment, running outdated software in buildings with leaking roofs.

In the Conservative Party leadership campaign, Liz Truss called for “fewer layers of management” in the NHS,¹⁰¹ yet the evidence suggests that the NHS in fact has too few managers, certainly compared to other countries and the private sector,^{102,103} with highly trained clinicians kept off the front line by admin work. It will be much harder to find efficiencies in the health service if its leaders lack the capacity to consider and implement reforms.

- **The government should consider these issues more carefully at future fiscal events, allocating money where it will have the greatest impact on public service performance. In particular, the government should build on the processes used in the 2021 spending review to align spending with priority outcomes,¹⁰⁴ using cross-departmental outcomes to foster greater collaboration between departments and ensure that spending decisions are not siloed.**

Improve the range and quality of data collected

High quality data is a prerequisite for good decision making in government. It enables better monitoring and evaluation of programmes and drives better outcomes for users.¹⁰⁵ Government open data also provides the public and parliament with information needed to hold government to account.¹⁰⁶ In evaluating performance across the nine public services discussed in *Performance Tracker*, we have identified important data gaps that public services need to address to better understand and improve their service delivery – most notably in relation to demand, with several public services lacking data on the unmet demands in their sector.

In some cases, these data gaps arose due to pandemic-related disruptions. In schools, assessment measures are either not available (primary school assessments, for 2020 and 2021) or are of limited use as an indicator of standards (secondary school assessments, 2020–22). Another example is local authority section 251 budget returns, which provide important information on school spending, but were not collected for 2020/21.

Covid also led to changes to some methodologies – for example, the police crime survey for England and Wales – meaning figures are now not comparable to pre-pandemic figures. The new methodology also lacks clear satisfaction estimates, a crucial metric for maintaining policing by consent. Future survey rounds should be updated to provide these figures.

In other cases, there has never been good quality data available. The government identified problems with securing GP appointments in *Our plan for patients*, but is missing fundamental data to understand the problem – above all, the number of rejected or unsuccessful appointment requests, for which there is no reliable estimate. There is also no public dataset on the outcome of ‘advice and guidance’ requests, such as whether a case is referred or rejected, or what then happens to rejected patients. There is also a need for data on the length of appointment by mode to understand the efficiency of telephone-based consultations. Finally, to better evaluate the performance of GPs, it would be helpful for greater data on the number of completed patient pathways in the primary health care sector.

Particular focus should be given to better social care data, including private funding of social care, staff/resident ratios, staff qualification levels in residential homes and home care, the number of unpaid carers, and what happens to adults who request but do not receive publicly funded adult social care. There is also a need for more frequent publication of NHS Digital's primary social care report – the Adult Social Care Activity and Finance Report – which is currently published only annually. Some of these recommendations match the government's own initiative 'Data saves lives'.¹⁰⁷ It will need to deliver this in full to realise this vision of better health and social care outcomes through data.

- **Government should improve the range and quality of public services data that it collects, and use this to drive the performance of these services.**

Well performing public services are necessary for a healthy, productive society. But many are not in good health themselves, and in many cases face a worsening picture in anticipation of a difficult winter, increased demand and the potential for at least some form of budget cuts. The following chapters in *Performance Tracker* provide an in-depth look at nine individual services: general practice, hospitals, adult social care, children's social care, neighbourhood services, schools, police, criminal courts and prisons.

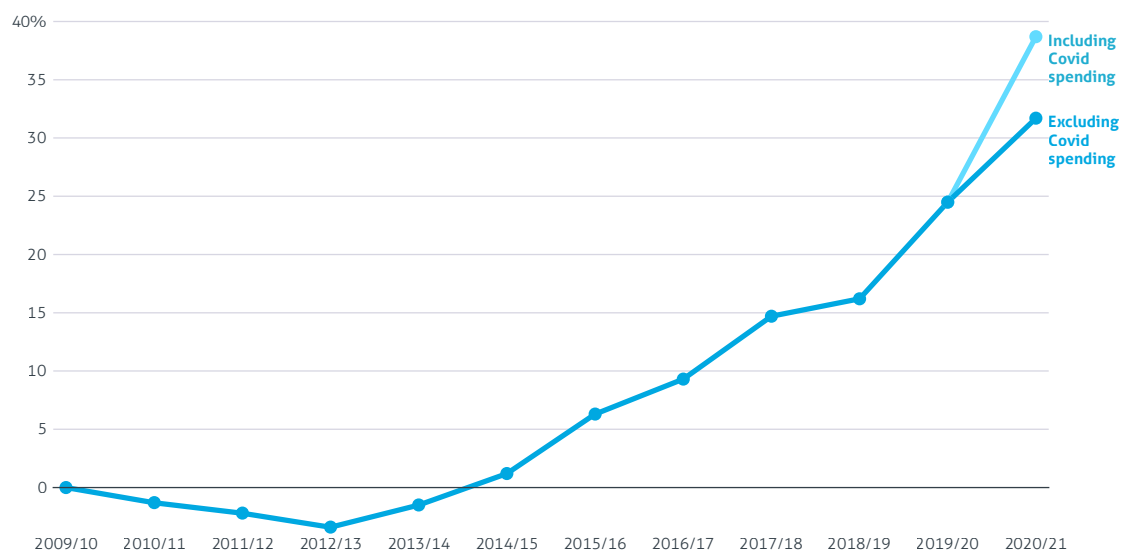
1. General practice

The pandemic affected general practice in different ways as it progressed. In the early stages, GPs conducted far fewer appointments as patients stayed away from the NHS. Then, during the rollout of the Covid vaccine, they played a key role delivering doses in their communities. Now, into the third year of the pandemic, general practice is attempting to cope with a huge surge in demand, as many of those who stayed away come forward for care. The level of pressure on an already overstretched workforce is immense: GPs delivered more appointments in 2021/22 than in any year on record.

Despite this increased activity, there is evidence that many people have tried but failed to book an appointment, contributing to increasing public dissatisfaction with the service. Those appointments that did take place were delivered in different ways, with a large proportion being carried out over the telephone. The outcomes of appointments also changed: referrals from general practice to secondary care dropped during 2019/20 (before the pandemic) and remained below pre-pandemic levels in 2020/21 and 2021/22. Despite a recruitment drive that has increased the number of GPs in training contracts and brought a large and rapid expansion of the wider primary care workforce, the combination of growing demand, additional responsibilities and new ways of working is worsening stress and burn-out, in turn contributing to a deteriorating retention of GPs in primary care.

Covid costs have driven high spending in general practice

Figure 1.1 Change in spending on general practice since 2009/10 (real terms)



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, 2016/17 to 2020/21', supported by CIPFA. Notes: Figures cover both current and capital spending.

Spending on general practice in 2020/21 was 35.5% higher in real terms including Covid costs, and 31.7% higher in real terms excluding Covid costs, than in 2009/10.¹ The increase in spending in 2019/20 and 2020/21 followed the launch of the NHS Long Term Plan, in January 2019, which aimed to increase spending on general practice and community health services by at least £4.5 billion by 2023/24² – a target that NHS England is currently on track to meet, even when excluding additional Covid spending.

NHS England spent £704.8 million on Covid measures in primary care in 2020/21.³ Of this, £333.8m related to the Covid vaccination programme, where GPs carried out a greater proportion of vaccinations than forecast and more affordably than dedicated vaccination centres – the average cost for each dose was £24 and £34 respectively.⁴ The remaining £371m included funding for measures such as opening on bank holidays, personal protective equipment (PPE) provision and an enhanced flu vaccination scheme.⁵ It is currently unclear how much NHS England will need to continue spending over the coming years to deal with ongoing Covid pressures in general practice.

Spending on staffing has also driven increased expenditure

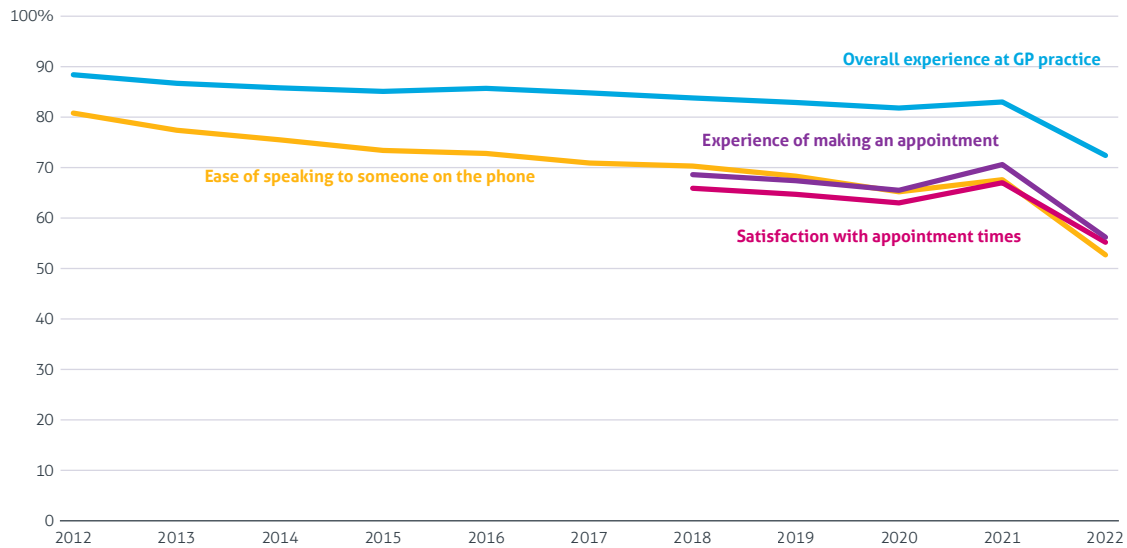
Spending on primary care organisations – a category that includes recruitment, retention, locum payments and seniority payments in general practice⁶ – increased 21.7% a year in real terms on average from 2018/19 (the last year before the NHS Long Term Plan came into effect) to 2020/21.⁷ This was partly to support the government's ambition to have a further 26,000 primary care staff⁸ and 6,000 GPs⁹ by March 2024, which would represent a 17.4% increase in the total number of GPs, compared with March 2019.¹⁰

Demand for general practice is reportedly high, but difficult to quantify

Demographic changes continue to push up demand for primary care. The population in England grew by 0.5% between 2019 and 2020, with the population aged 65+ growing by 1.2%.¹¹ Adjusted for age- and sex-based factors, demand for GP services is estimated to have risen 0.6% in 2022 compared with 2021, due to purely demographic factors.¹²

However, this projection is unlikely to represent true levels of demand since the pandemic. Interviewees and anecdotal reports indicate that primary care is facing more demand than ever, although this is difficult to quantify: NHS England records the numbers of appointments that GPs and other primary care staff carry out, but not how many people try but fail to book an appointment.

Figure 1.2 Patients' experiences of general practice, 2012–22



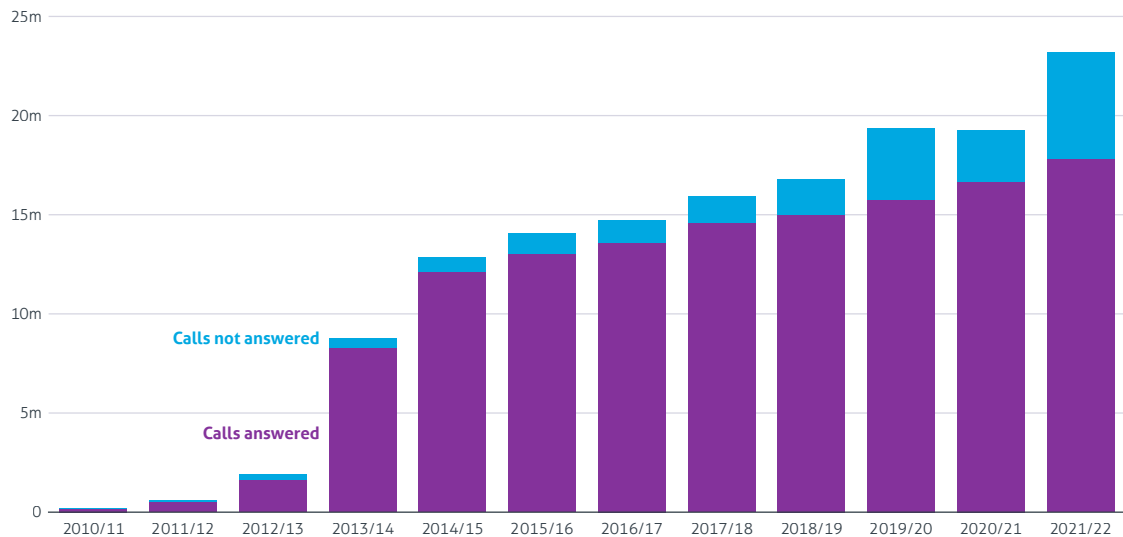
Source: Institute for Government analysis of NHS, 'GP Patient Survey 2022', questions 1, 6, 21 and 32, supported by CIPFA. Notes: Each time series starts from the first year the question was asked.

However, surveys of patients registered with a GP practice indicate that unmet demand is substantial and has increased. In the annual GP Patient Survey, only 56.2% rated their experience of making an appointment as 'good' or 'better' in 2022, down from more than 70% in 2021. And among those who avoided making a GP appointment in 2022, 26.5% did so because they found it too difficult, up from 11.1% in 2021.¹³

The survey indicates that, overall, satisfaction with the service that general practice teams are providing is down: only 72.4% described their experience as 'good' or 'very good' in 2022, down from 83% a year earlier. Patients' inability to make appointments, due to excessive demand, appears to be a major driver of this.

In September, the new government headed by Liz Truss announced an ambition for every patient to see a GP within 14 days. But little additional resources have been provided to deliver this and practices will not face any meaningful consequences for failing to do so.¹⁴

Figure 1.3 Calls to the NHS 111 service, 2010/11–2021/22



Source: Institute for Government analysis of NHS England, 'NHS 111 Minimum Data Set', March 2021 and NHS England, 'Integrated Urgent Care Aggregate Data Collection (IUCADC including NHS 111) Statistics, Apr 2021–Mar 2022', supported by CIPFA. Notes: The 111 service was first piloted in 2011.

Another proxy for health demand – and, by extension, demand for GP services – is the number of calls made to the NHS 111 service. The number of calls that the service *received* rose to 23.2 million in 2021/22,¹⁵ a 20.5% increase from the 19.2 million received in 2020/21.¹⁶ But the proportion of calls that the service *answered* fell from 86.6% in 2020/21 to 76.9% in 2021/22.

GP teams carried out more appointments in 2021/22 than before the pandemic, but it is unclear whether they saw more patients

Figure 1.4 Appointments in general practice by provider, Q3 2018/19 to Q1 2022/23



Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, June 2022', supported by CIPFA. Notes: Data was first published in 2018/19.

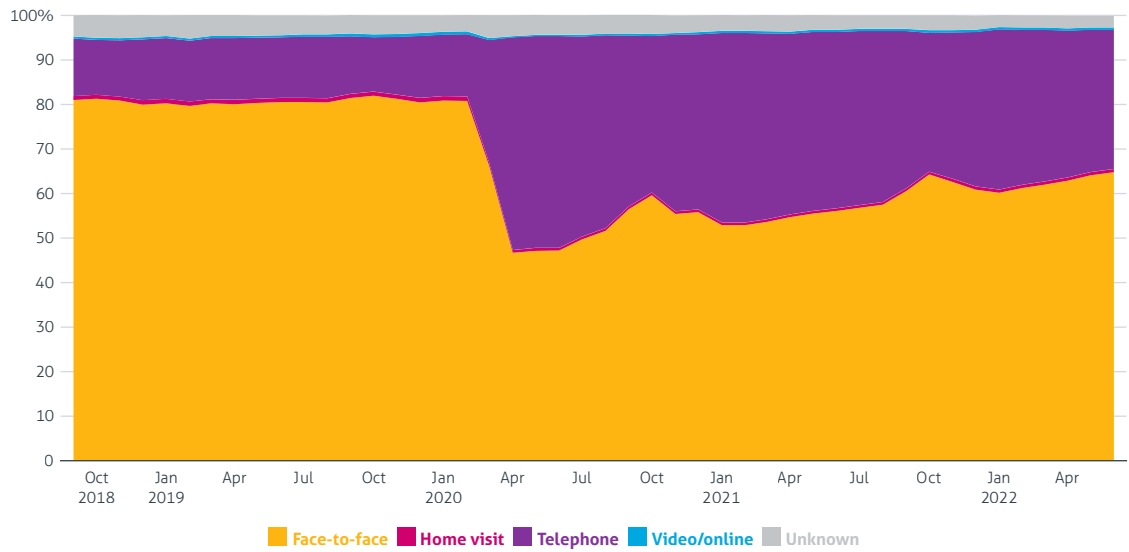
After a decline in 2020/21, the number of general practice appointments delivered in 2021/22 rose above the amount carried out in 2019/20. This was true for both GP appointments (which rose from 154.2 million in 2019/20 to 161.9 million in 2021/22, a 5% uplift) and appointments with other practice staff, such as practice nurses, physiotherapists or counsellors (which increased from 136.7 million in 2019/20 to 146.2 million in 2021/22, a 7% rise).

While the number of appointments overall increased, this data is not comparable to previous years. With a 'telephone-first approach', GPs can end up conducting two, shorter appointments for some patients – an initial telephone appointment followed by a face-to-face appointment – which would previously have been recorded as one, longer appointment. It is therefore difficult to tell whether GPs are actually seeing more patients, or just recording more appointments because patients require both telephone and in-person appointments to resolve their health problem.

Appointments are also not the only component of GP workloads – just under 60% of GPs' time is spent on direct patient care,¹⁷ meaning that 40% of GP activity is not observed by looking at appointment data.

GPs continue to deliver appointments differently

Figure 1.5 GP appointments by mode of delivery, September 2018 to June 2022



Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, June 2022', supported by CIPFA. Notes: Data was first published in 2018/19.

The way that appointments are delivered has also changed. In the year to February 2020, telephone appointments accounted for only 13.5% of all consultations. In April 2020, this increased to 47.8%, and has remained high, although declining, since. In 2021/22, GPs conducted 34.1% of appointments by telephone. This trend has persisted despite the NHS issuing guidance in May 2021 that all GP practices should offer patients face-to-face appointments and that patient preferences for face-to-face consultations should be respected.

The move during the pandemic to an 'online triage' model may also partly explain the trend.¹⁸ Having completed an online triage form, GPs often follow up with a telephone appointment, which might then lead to a face-to-face appointment.¹⁹

The continuation of this mode of appointment delivery may also be because patients often prefer it. Telephone appointments eliminate the need for people to attend and wait in a GP surgery, saving them time and money. This can translate into higher patient satisfaction: one survey showed that 58% of patients either agreed or strongly agreed that telephone appointments were a convenient way of receiving care,²⁰ while another survey showed that 56% of respondents rated telephone appointments as more convenient than face-to-face ones.²¹

But there are disadvantages for patients with a 'remote-first approach'. There is a risk that it exacerbates existing inequalities²² among vulnerable and elderly patients.²³ There is also concern that remote appointments lead to worse clinical outcomes for patients,²⁴ although more work needs to be done to understand their effect on outcomes.

The benefits to GPs of increased numbers of remote appointments are mixed

The benefits of remote appointments for clinicians are more ambiguous than they are for patients. Some clinicians like working remotely and, during the pandemic, appreciated that they were able to work with a lower risk of catching Covid. Telephone appointments were found to be effective for "a considerable part of patient workload",²⁵ in particular simpler, single-issue problems.²⁶ But for more complex or uncertain cases, GPs asked patients to attend a face-to-face appointment for further examination.

There are also clinical risks associated with remote consultations. For example, GPs reported issues such as a loss of visual information, a loss of information from a physical examination²⁷ and a reduced incidence of patients raising 'door knob' concerns as they left their appointment.²⁸

Telephone consultations also contributed to GPs' stress, for a number of reasons.²⁹ First, GPs often found it difficult to extract a full history from patients remotely, which reduced their confidence in their diagnoses.³⁰ Second, if working from home, they lost the ability to consult with colleagues in the way they would have done if they had been in the GP surgery.³¹ Third, they often found telephone and video calls more tiring than face-to-face appointments³² and that telephone appointments often increased the amount of time they spent working.³³ Finally, GPs felt that remote appointments were more transactional, which in turn lowered their job satisfaction.³⁴

Referrals to secondary care dropped after the onset of the pandemic and have remained low

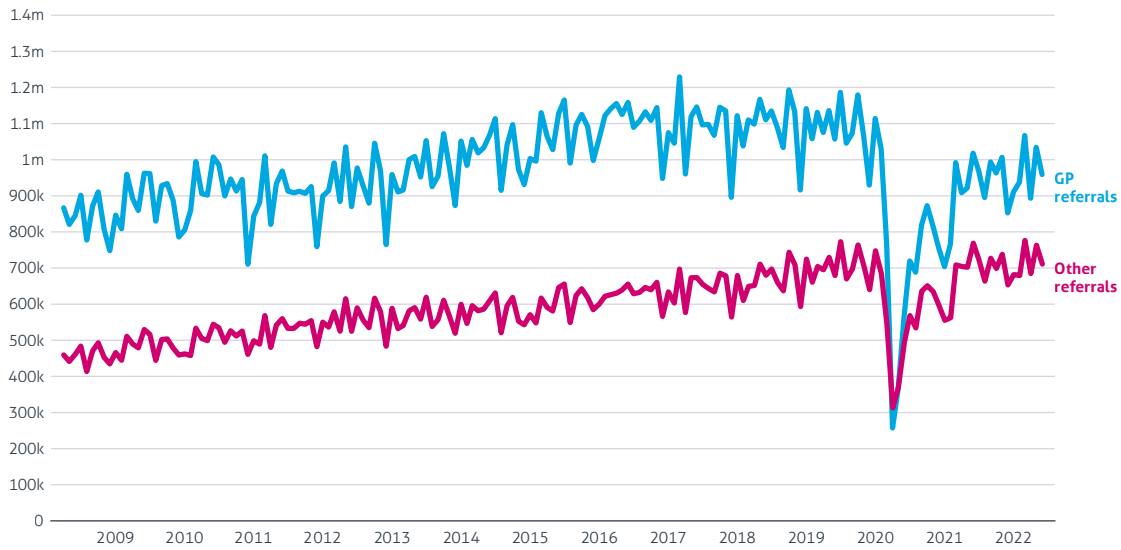
Figure 1.6 GP appointments resulting in a specific and acute referral, October 2018 to June 2022



Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, June 2022' and NHS England, 'Monthly Outpatient Referrals Data, Outpatient Referrals Time-series, June 2022', supported by CIPFA. Notes: Appointments are attended GP appointments; data was first published in 2018/19.

Whether or not GPs are working more or seeing more patients, the data shows that they are less likely to refer patients to hospital. The proportion of GP appointments that have resulted in a specific and acute referral has dropped over the course of the pandemic. But we are not seeing referral rates return to pre-pandemic levels. Between October 2018 (when the appointment time series began) and February 2020, 9% of GP appointments resulted in a referral. This fell to 6.2% between March 2020 and February 2021. From March 2021 to March 2022, the rate increased to only 7.7%, despite the expectation that more patients would require referral to secondary care – having been unable to access care during the pandemic.³⁵

Figure 1.7 **Specific and acute referrals to NHS secondary care by source per month, April 2009 to June 2022**



Source: Institute for Government analysis of NHS England, 'Monthly Outpatient Referrals Data, Outpatient Referrals Time-series, June 2022', supported by CIPFA.

The lower rate of referral has translated into fewer absolute referrals, despite more appointments taking place. The number of specific and acute referrals – from both GPs and other sources – was 20 million in 2021/22, down from 21 million in 2019/20. This is despite a drop in referrals to 15 million in 2020/21, which could have indicated pent-up demand for referrals to secondary care.

There are multiple reasons for this decrease. First, there was a slight downward trend in referral rates before the pandemic, which, if continued, could explain some of the observed decline, although this was not a long-running trend and there was no particular reason to expect it to continue. Second, there are claims that hospitals are blocking referrals,^{36,37} although this should not affect the overall number of referrals, as we observe referrals when a GP refers a patient, whether or not there is then a follow-up appointment.³⁸ Third, it may be that, before making a referral, GPs are following up initial telephone appointments with face-to-face consultations, meaning more appointments taking place for each referral, on average.

Figure 1.8 GPs' requests for advice and guidance using the NHS e-Referral Service, January 2019 to June 2022



Source: Institute for Government analysis of NHS England, 'Monthly Outpatient Referrals Data, Outpatient Referrals Time-series, June 2022', supported by CIPFA. Notes: Advice and guidance (A&G) was introduced in 2019.

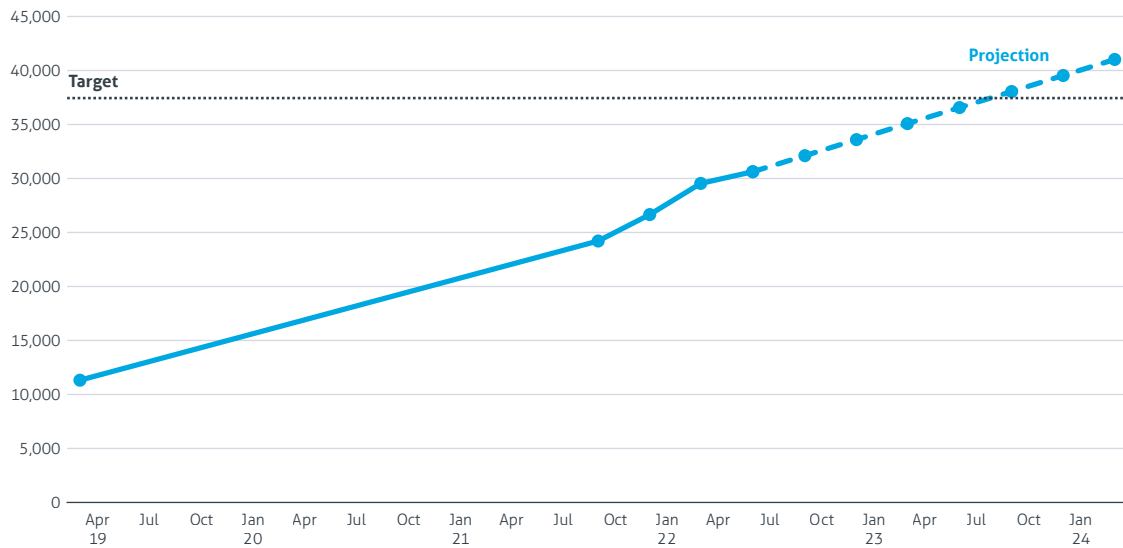
Fourth, and arguably most importantly, is new encouragement from NHS England for GPs to consult their secondary care colleagues in advance about whether a referral is the best course of action. This mechanism is known as 'advice and guidance' (A&G). NHS England has introduced a target for GPs to register 16 specialist advice requests, including A&G, for every 100 first outpatient appointments, by March 2023.³⁹

There are advantages and disadvantages to the increased use of A&G. It can help speed up treatment and enable patients to receive the care they need closer to home. NHS England also claims that the 1.6 million total A&G requests in 2020/21 resulted in 1 million fewer "unnecessary face-to-face outpatient attendances",⁴⁰ thus helping to ease the pressure on secondary care. In contrast, some argue that mandated A&G ignores GPs' better judgement⁴¹ and increases the risk that patients who A&G screens out return to primary care, increasing demand for that service.⁴²

The wider primary care workforce is growing, in line with government targets

In 2019, the NHS announced its ambition to recruit an extra 20,000 direct patient care (DPC) staff – in particular, clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics⁴³ – by March 2024.⁴⁴ The Conservative Party then added to this goal in its 2019 election manifesto,⁴⁵ bringing the total target to 26,000 additional DPC staff. The aim of this recruitment drive is to reduce some of the burden on GPs and thereby support the broader target of delivering 50 million more general practice appointments by 2024.⁴⁶ The NHS is now supporting primary care networks to recruit these staff by reimbursing them for any staff hired in addition to the baseline that was set in March 2019 under the Additional Roles Reimbursement Scheme (ARRS).

Figure 1.9 DPC staff employed in primary care networks, March 2019 to March 2024

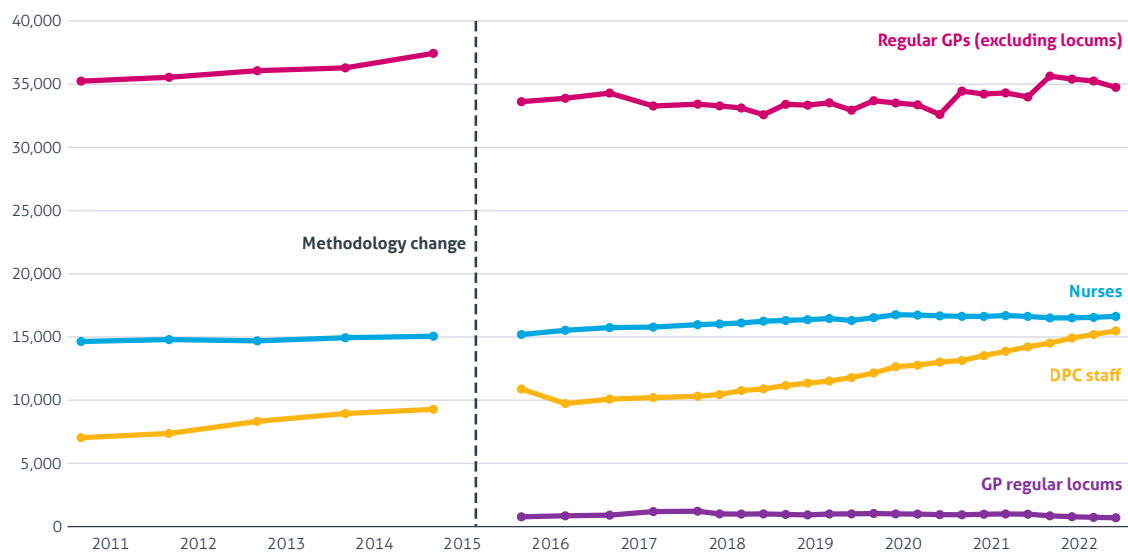


Source: Institute for Government analysis of NHS Digital, 'Primary Care Workforce Quarterly Update, 30 June 2022', supported by CIPFA. Notes: Quarterly data between March 2019 and September 2021 was not published.

The NHS only began releasing quarterly data updates on the number of staff employed under the ARRS scheme in September 2021. From that time series, the total number of DPC staff increased from 11,321 in March 2019 to 30,626 in June 2022. This is an increase of 19,305 staff – a 70.5% rise in just over three years. If recruitment continues at the same rate as it has to date, the NHS will recruit more than 29,000 more DPC staff by March 2024 – more than 3,000 in excess of the target.

But there are a number of concerns about the implementation of this recruitment drive. First, it is not clear that primary care networks – still relatively new themselves – have a clear vision for these new employees. This means that new staff members are not being effectively used.⁴⁷ Second, GP practices are concerned about the financial sustainability of the DPC workforce when the additional funding ends in 2023/24. As it stands, there is no guarantee that funding will continue, meaning that a number of DPC staff could lose their jobs when the scheme comes to an end.⁴⁸ Third, the expansion of the primary care workforce may be putting additional pressure on GPs. Some GPs report that DPC staff take on the easy cases, leaving GPs with the more complex casework. In addition, GPs are required to take on a greater supervisory role as they manage a larger team.⁴⁹

Figure 1.10 **General practice primary care workforce by role, full-time equivalent, September 2010 to June 2022**



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015–June 2022' and NHS Digital, 'General and Personal Medical Services, England, 2004–14, as at 30 September', supported by CIPFA. Notes: There is a break in the dataset between 2014/15 and 2015/16 due to a change in methodology; the number of direct patient care (DPC) staff in this chart is not directly comparable with the number of DPC staff in the chart titled 'Number of DPC staff employed in primary care networks: March 2019–March 2024' (Figure 1.9). 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.

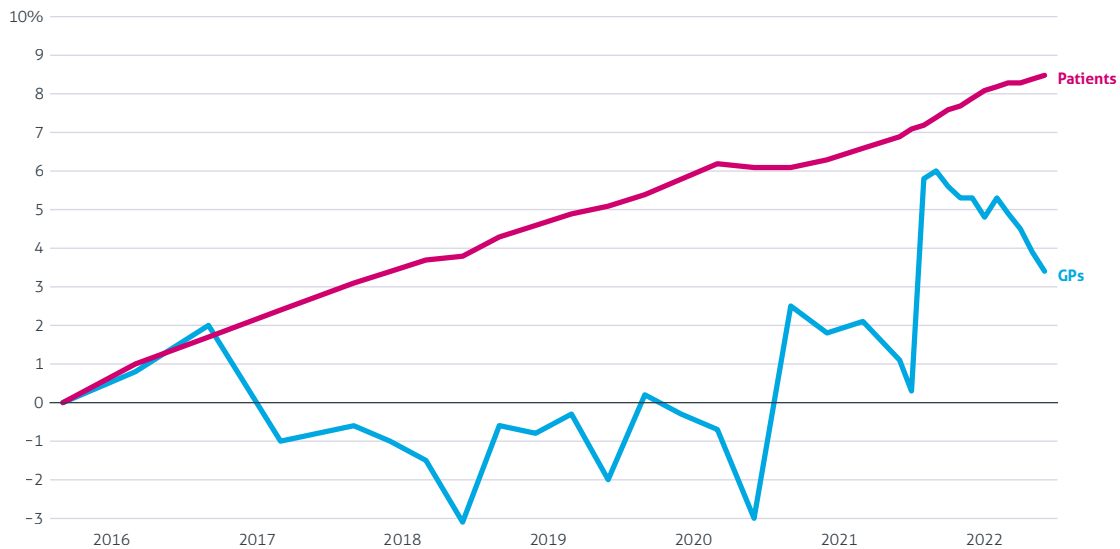
The number of GPs has grown, but not by enough to meet demand

The number of regular GPs increased between 2020/21 and 2021/22. There were 34,749 regular, full-time equivalent (FTE) GPs in June 2022 – 756 (2.2%) more than in the same month in 2021.⁵⁰ Boris Johnson made GP recruitment one of his core election commitments, promising to increase the number of GPs by 6,000 between March 2019 and March 2024.⁵¹ By March 2022, there were 1,728 more regular GPs than in March 2019,^{*} meaning that the government is not on track to hit its target by 2024, assuming similar levels of recruitment and retention.⁵²

Regular GP numbers include GPs in training grades – which accounted for 7,890 of the 34,749 GPs in England (or 22.7%) in June 2022.⁵³ There has been an increase in the number of GPs in training grades recently as the government has pushed for improved GP recruitment, from 5,857 in June 2019 to 7,890 in June 2022. Excluding GPs in training grades and locums, the number of fully qualified, FTE GPs was 26,859 in June 2022, a decline of 6.1% since September 2015, the start of this time series.⁵⁴

* We compare March 2022 to March 2019 despite there being more recent data (to June 2022) because there is seasonality in the number of GPs in training grades, which we include in our total number of GPs. There is a large spike in the number of GPs in training grades in September every year, as doctors complete their second foundation year of training and start their GP training course. There then tends to be attrition throughout the year, meaning that comparing June 2022 with March 2019 might make the current level of GPs look artificially low.

Figure 1.11 **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–June 2022', supported by CIPFA. Notes: Data was first published in 2015/16.

The introduction of the recruitment target in 2019 reversed the trend of declining GP numbers (including those in training grades) and, as a result, these were 3.4% higher in June 2022 than in September 2015.⁵⁵ But increasing GP numbers are not keeping pace with demand for services. The number of patients registered with GPs grew 8.5% over the same time period.⁵⁶

This increase in patient numbers also does not take into account the changing demographics of the population – patients are now, on average, older than in 2015 and therefore in need of more care. There are also increasing rates of people living with multiple long-term conditions, both in the 65+ and working-age populations. One study estimates that the proportion of people over the age of 65 with more than one condition could rise from 54% in 2015 to 68% in 2035.⁵⁷ Among working-age adults, 34% now have chronic health conditions at ages 46–48.⁵⁸ This in turn drives higher demand for primary care services.⁵⁹

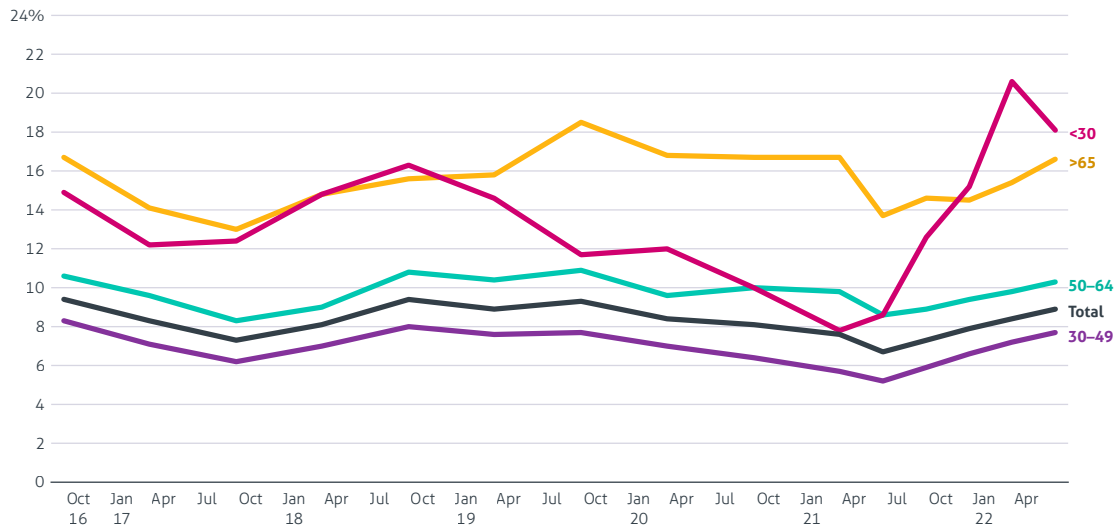
GP trends are worsening the mismatch in supply and demand

Workforce trends that are seeing more GPs working part-time or leaving the service are exacerbating the problem of demand for general practice services outstripping the supply of GPs. By June 2022, 76.5% of GPs worked fewer than 37.5 hours a week, compared with 66.7% in September 2015.⁶⁰

But headline figures in relation to the increasing number of part-time GPs hide a more complex picture. Part-time GPs often work up to or more than the 37.5 hours required of their FTE colleagues, while FTE GPs can work 50 hours a week or more.⁶¹ This is partly because working hours are measured by how many 'sessions' a GP carries out a day – a crude measure that only takes into account the time that GPs spend with patients. In reality, GPs must finish administrative work after the end of a session.⁶²

The higher workloads discussed above are contributing to GP stress and worsening retention in primary care. When polled, GPs identified increased workloads and increased demand from patients as the two factors that most contribute to increasing levels of stress, and they rated 'hours of work' as the category with the lowest overall satisfaction.⁶³

Figure 1.12 **GPs leaving the NHS by age group, full-time equivalent, September 2016 to June 2022**



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, GP Joiners and Leavers 2015–June 2022', 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.

After an improvement during the pandemic that saw a low of only 6.7% of GPs leaving the service in the 12 months to June 2021, retention has gradually worsened again, reaching 8.9% in the 12 months to June 2022.⁶⁴ It should also be noted that because this is a 12-month rolling average, the measure does not fully capture any recent large increases in the number of GPs leaving the service. Of concern is that the age group with the largest increase in the proportion leaving the workforce is the under-30s, where 20.6% of the workforce left the service in the 12 months to March 2022. This trend is worrying for the future GP workforce. If the under-30 cohort leaves in large numbers, then there will be fewer GPs in the future to staff the service.

2. Hospitals

By any reasonable measure, hospitals are in crisis. The proportion of people waiting more than four hours at A&E is the highest on record, ambulances are taking longer to respond to calls than at any time since the NHS started publishing data, the waiting list for elective care is the highest it has ever been (and not expected to start coming down until 2024), and the number of outpatient appointments and diagnostic tests done in hospitals has still not returned to pre-pandemic levels.

The pandemic forced the NHS in England to suspend much of its normal hospital work and encourage people to actively stay away from hospitals. Beds that would have been used for routine activity were repurposed for Covid patients as hospitals struggled to meet the demands of each successive wave of the virus. As a result, the number of outpatient appointments, diagnostic tests and elective procedures all declined sharply in 2020/21.

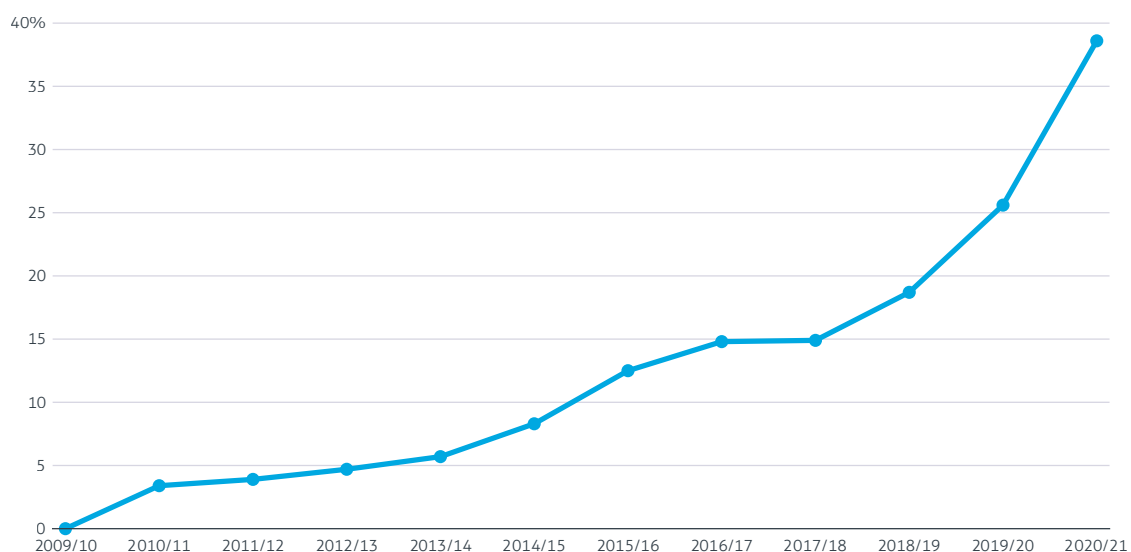
The NHS attempted to return to normal operations in 2021/22 and has become better at ramping up and down its Covid capacity as required, but is still struggling with the effects of the pandemic, which continue to reduce hospital productivity.¹ However, factors outside of Covid – namely pre-pandemic trends of declining bed numbers, an overstretched workforce, increasing numbers of workforce vacancies and delays in discharging patients into social care – all continue to contribute to the immense pressure that hospitals are under.

The coming winter is likely to be a difficult one for the NHS. The yearly peak in demand – which has in effect become an ‘annual winter crisis’ – coincides with an ongoing and worsening staffing situation, with almost 10% of NHS roles vacant at the end of June 2022.² Covid has also not gone away and will continue to divert NHS resources away from regular activity. The government and the NHS have attempted to address some of these issues with the release of two plans (‘Next steps for urgent and emergency care’³ and ‘Our plan for patients’⁴), but while both accurately diagnose some of the problems in the service, neither come close to laying out a sufficiently clear, ambitious or well-resourced set of steps to solve them.

This chapter discusses NHS acute and specialist trusts in England, which provide specific short-term treatments, including diagnostic services, outpatient treatment and services, emergency treatments – such as ambulances and A&E – and surgeries. As data relating solely to acute and specialist trusts is not always available, in some places we analyse corresponding data for all NHS trusts.

Spending increased by 10.4% in 2020/21, but much of this was Covid-related

Figure 2.1 Change in spending on NHS providers in England since 2009/10 (real terms)



Source: Institute for Government analysis of DHSC annual accounts, 2020/21, note 2.2, supported by CIPFA.

Spending on NHS providers – which includes NHS acute trusts, ambulance, community and mental health services – increased by 10.4% in real terms between 2019/20 and 2020/21. This was the biggest single-year spending increase since 2009/10 and brings the total increase in spending since then up to 38.6% in real terms. However, 2020/21 was also the first year of the pandemic and it should be expected that the NHS would increase spending to match the increased pressure imposed on hospitals.

Unfortunately, it is not possible to determine how much of the spending in that year was Covid-specific, but overall spending should either fall or grow less slowly in the coming years as Covid spending is rolled back,⁵ though it is likely that there will be continuing Covid-related spending in the medium to long term.

Another key area where spending increased was on staffing, which rose 8.7% between 2019/20 and 2020/21. This increase was driven by a mixture of higher spending on recruitment in line with ambitions in the NHS Long Term Plan (LTP)⁶ and emergency spending on staffing due to Covid.

The increase in spending on hospitals since 2019/20 comes in the wake of a period of historically low spending increases for the service. Spending on hospitals increased by 1.6% per year in real terms between 2009/10 and 2014/15 – compared to an average of 6.3% per year in the decade to 2009/10.⁷

Hospitals will continue to incur Covid costs

Hospitals face continuing spending pressures from preventing the spread of Covid to responding to outbreaks of different variants. The National Audit Office (NAO) estimates that the government spent £89bn between March 2020 and June 2022 to support health and social care services through the pandemic.⁸ Estimating future cost, though, is more difficult. It is unclear how frequently Covid waves will occur and also difficult to accurately differentiate Covid costs from business-as-usual costs.⁹

In addition, the emergence of new variants might require the reintroduction of 'mass vaccination and testing'¹⁰ measures that would entail an expansion of NHS spending. There are, however, reasons to believe that the emergence of another variant would not require the same extent of funding as previous variants. According to interviewees, the NHS has become more efficient at responding to Covid, taking less time – and therefore spending less money – to increase Covid capacity. Despite this, a joint report by NHS Confederation and NHS Providers, which uses survey data from 54% of NHS providers, estimates that the NHS will need to spend an additional £4–5bn per year on Covid-related costs "for some years to come".¹¹

Hospitals found some efficiencies during the pandemic

The pandemic encouraged the NHS to develop new ways of working. Some proved to be effective and could lead to longer-term – though not transformative – savings across the NHS. These innovations can be grouped into three categories.

First, more efficient use of existing resources. For example, hospitals expanded the use of 'mutual aid' – the sharing of resources such as vaccines¹² and staff between different NHS providers – to reduce wastage and improve productivity.

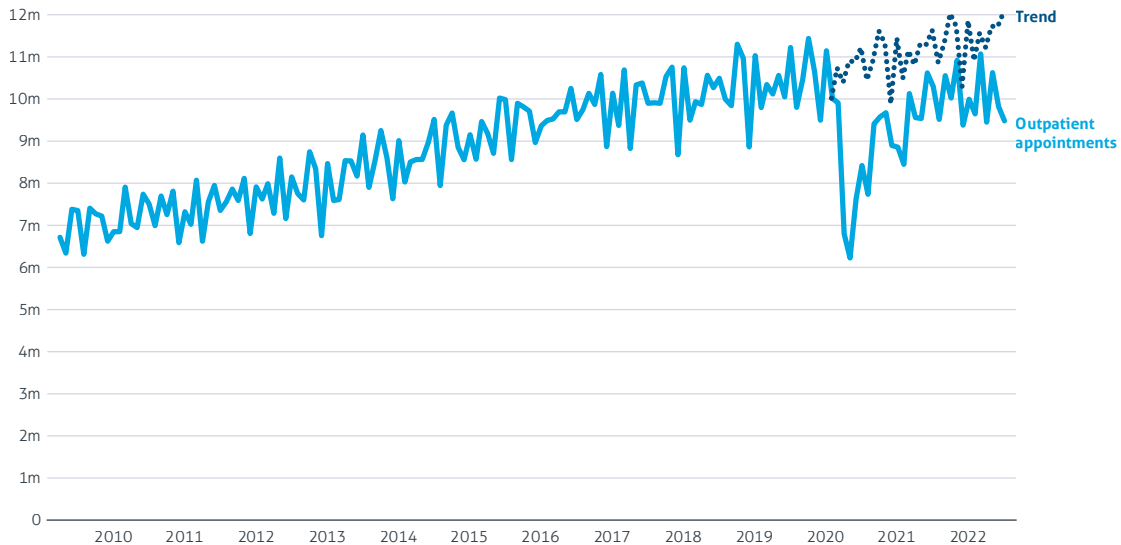
Second, measures designed to keep people away from hospitals. Examples include the use of virtual wards^{13,14} (in which hospital staff remotely monitor patients who stay in their own homes), increasing the number of virtual outpatient appointments¹⁵ and carrying out acute services in the community.^{16,17} There were 53 virtual wards providing 2,500 virtual beds in February 2022,¹⁸ and the NHS has an ambition to increase this capacity to "40–50 virtual beds per 100,000 population".¹⁹ This would equate to approximately 23,000–28,000 virtual beds²⁰ – or around a quarter of the currently available general and acute beds. Virtual wards are still, however, a relatively new innovation and there is not enough evidence to evaluate their effectiveness.²¹ In addition, while not physically being in a hospital, staff still need to monitor the status of patients in virtual beds,²² which may prove difficult given current staffing issues (more on which below).

Finally, hospitals have attempted to reduce unnecessary activity. One lever for this is the introduction of 'patient initiated follow-up' (PIFU),²³ which places the onus on patients to arrange follow-up appointments when they think they are necessary. This has the potential to free up capacity in the NHS; follow-up appointments accounted for 67.8% and 69.7% of attended outpatient appointments in 2019/20²⁴ and 2020/21²⁵ respectively.

The NHS hopes that its target of “moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023”²⁶ will help it to achieve its wider target of reducing outpatient follow-up appointments by 25% by March 2023.²⁷ There remain questions about this approach, however. There is still little evidence that PIFU reduces unnecessary appointments and concerns that it could contribute to health inequalities.²⁸

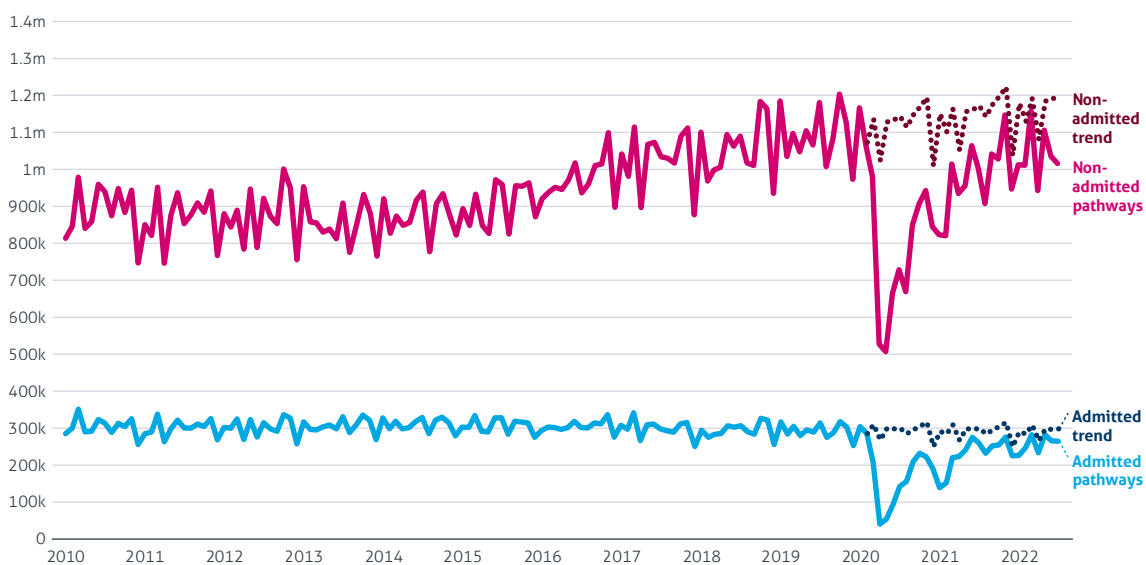
Hospital activity has not returned to pre-pandemic levels

Figure 2.2 **Outpatient activity in hospitals, actual and trend in the absence of Covid, April 2009 to July 2022**



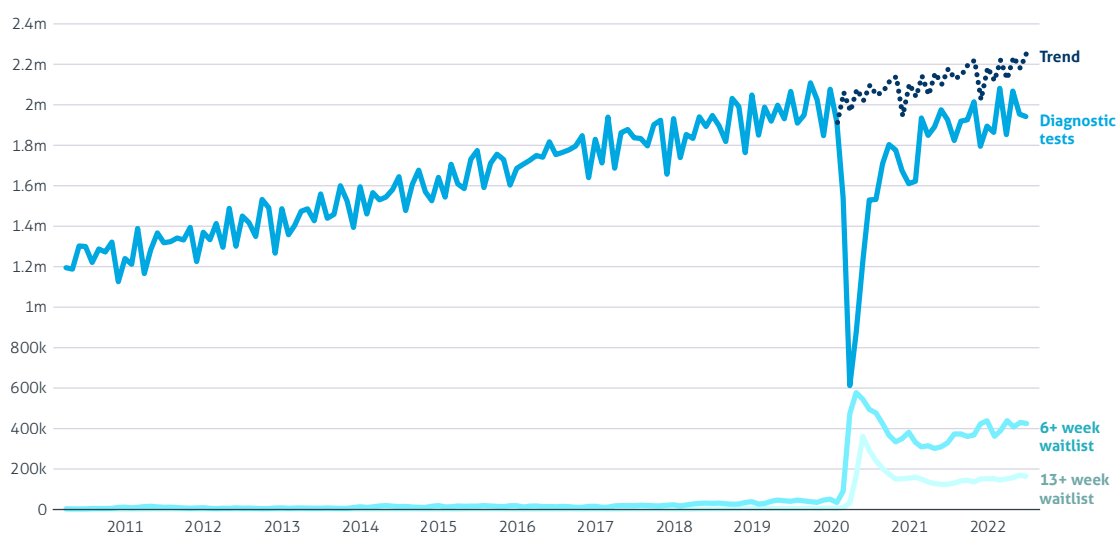
Source: Institute for Government analysis of NHS Digital, 'Monthly Hospital Episodes Statistics for Admitted Patient Care and Outpatients' 2009/10-2022/23, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Figure 2.3 **Elective activity by pathway, actual and trend in the absence of Covid, January 2010 to July 2022**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times', July 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Figure 2.4 **Diagnostic tests, actual and trend in the absence of Covid, and waiting lists for diagnostic tests, April 2010 to July 2022**



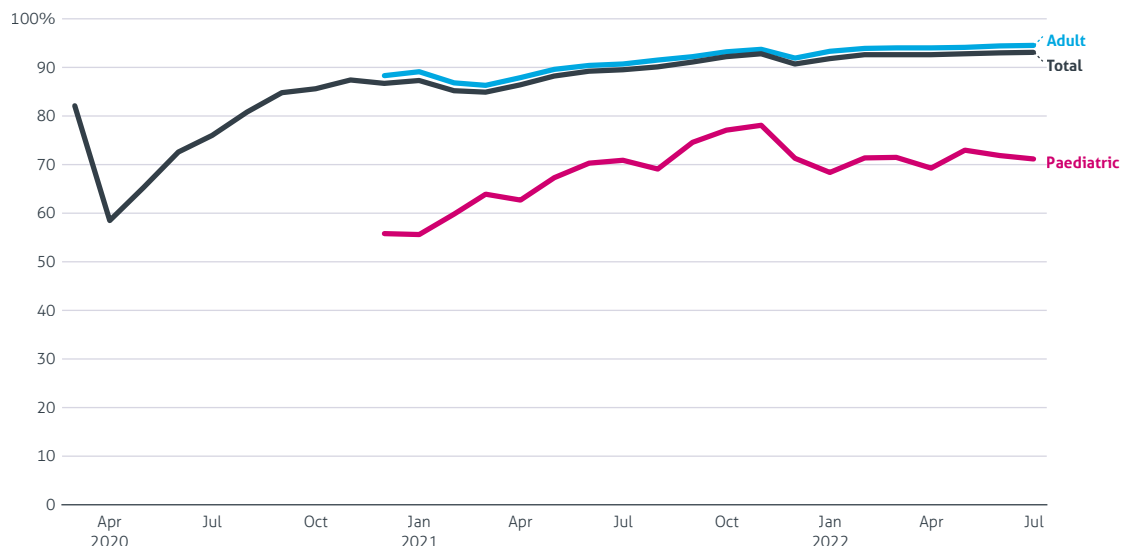
Source: Institute for Government analysis of NHS England, 'Monthly diagnostic waiting times and activity', Table: Total Activity, Table: 6+ week waits, Table: 13+ week waits, July 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Hospital activity dipped during the pandemic and has not returned to trend levels. The NHS conducted 22.9 million diagnostic tests (including tests carried out in non-hospital settings) in 2021/22, compared to 23.4 million in 2019/20, and 121.2 million compared to 124.9 million outpatient appointments in the same two years. These outcomes represent a decline of 1.4% and 3% respectively. Concerningly for the NHS's ability to clear the backlog, the number of elective procedures fell from 16.4 million in 2019/20 to 15.2 million in 2021/22.

There are two key reasons for this decline. First, the pandemic has made it harder for the NHS to carry out routine procedures in hospitals.²⁹ Spikes in Covid cases cause higher bed occupancy and greater infection control requirements – for example, having at least one vacant bed space between each occupied bed – meaning that there is less space available for procedures.³⁰ Second, increased staff absences and vacancies make it difficult for hospitals to return to pre-pandemic levels of activity.³¹ These pressures have not gone away despite the return to post-pandemic normality elsewhere in the country; hospitals are still dealing with Covid and expect to for the foreseeable future.

High bed occupancy is limiting NHS capacity

Another drag on hospital performance is patients staying in beds longer than needed.³² On average between 29 November 2021 and 31 August 2022 (the time period covered by the Daily SitRep data³³), 21,124 patients per day no longer met the criteria to reside in hospital. On average more than half (57.7%, 12,179) of this number remained in hospital at the end of the day. With 98,016 general and acute beds available across all acute trusts in July 2022, this means that 12.4% of bed capacity on an average day was occupied unnecessarily.

Figure 2.5 **General and acute bed occupancy, March 2020 to July 2022**

Source: Institute for Government analysis of NHS England, 'Critical care and general & acute beds – urgent and emergency care daily situation reports', Table: Time series type 1 acute trusts, July 2022, supported by CIPFA. Notes: A split between adult and paediatric general and acute beds was not available before December 2020.

The data for patients in hospitals for more than 21 days is worse. Between 29 November 2021 and 3 April 2022 (the time period for which this data is available), 6,143 patients per day remained in a bed 21 days or more after being eligible for discharge. Of these the vast majority (5,479 patients, 89.2%) continued to occupy a bed at the end of the day, mostly due to a lack of appropriate places to discharge them to. Beyond the unnecessary occupancy of limited bed capacity, delayed discharge also uses up clinical resource, as staff have to care for patients that remain in hospital, diverting attention away from those more in need of care.

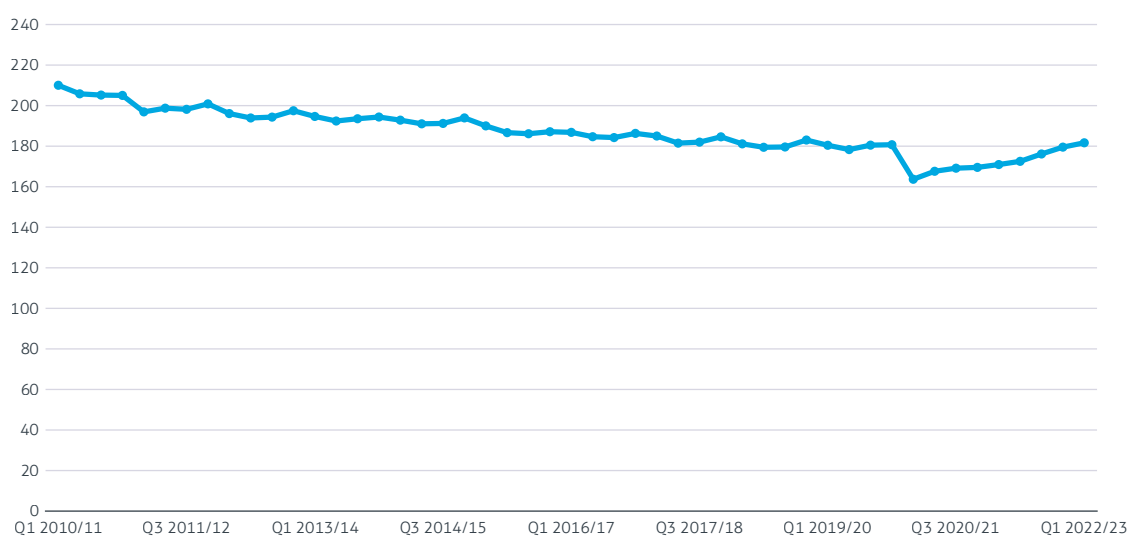
After a decline at the beginning of the pandemic, occupancy of general and acute (G&A) beds has increased steadily and has been above 90% every month since August 2021, reaching a high of 93.1% in July 2022, the most recent month for which we have data.³⁴ This high occupancy is concerning for the performance of hospitals as it makes it difficult to admit patients.

Unfortunately, following the suspension of the Delayed Transfer of Care dataset in February 2020, there is no longer official data on the cause of these delayed discharges.³⁵ But interviews point to several reasons. First, limited staffing, both among social workers in local authorities who carry out assessments for care,³⁶ and in care workers, reduces the number of available care places into which hospitals can discharge patients. Second, there is a lack of available NHS community care that is preventing hospitals from discharging patients in a timely manner, increasing the reliance on social care.³⁷ This was likely worsened at the beginning of 2022 by the redeployment of community care staff to the vaccination programme.³⁸ Third, hospitals themselves can cause delays due to a lack of intermediate care – for example, respite and rehabilitation services – needed to facilitate a patient's discharge from hospital.³⁹

In September 2022, the government announced a £500m Adult Social Care Discharge Fund, with the aim of making it easier for hospitals to discharge patients into social care.⁴⁰ However, this does not appear to be additional funding and is unclear whether it will substantially improve the rate at which hospitals discharge patients.

While bed occupancy increased during the pandemic, the shortage of beds pre-dates Covid. The number of overnight general and acute beds per 100,000 people has declined steadily since 2010/11, from a high of 210.0 beds per 100,000 people in the first quarter of 2010/11 to 176.1 by the first quarter of 2022/23 – a decline of 16.1%.

Figure 2.6 **Overnight general and acute hospital beds per 100,000 people, April 2010 to June 2022**

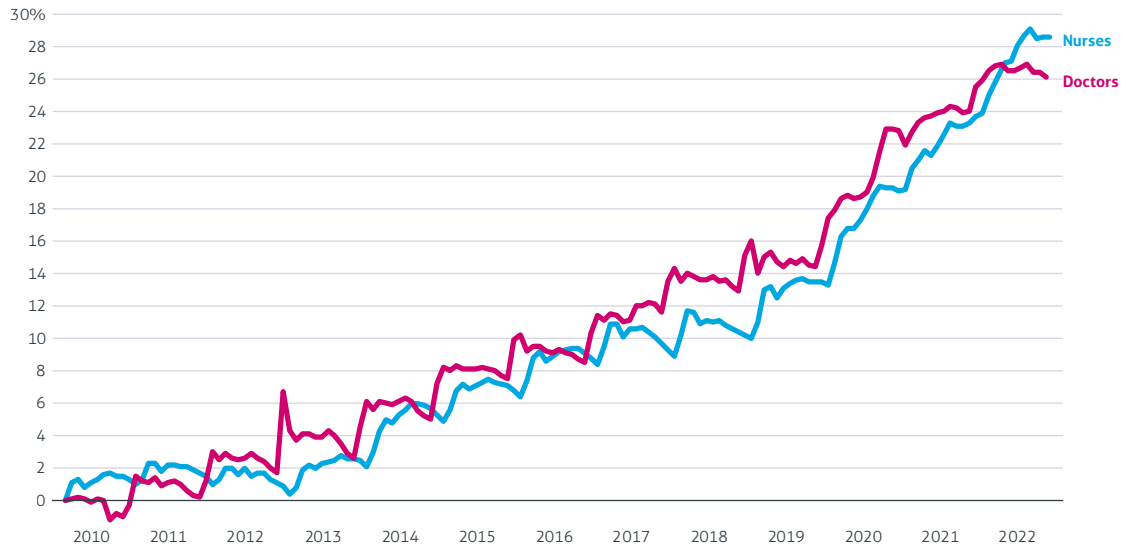


Source: Institute for Government analysis of NHS England, 'Bed availability and occupancy data – overnight', Table: Average daily available and occupied bed time series – open overnight, Q1 2022/23; ONS, 'Mid-year population estimates', Table: MYE1 population estimates: summary for the UK, mid-2020, 2021, supported by CIPFA. Notes: Data was released for the first time in 2010/11; see Methodology for further details.

Fewer open beds means that the NHS is less well equipped to deal with Covid surges and elective and emergency activity. This worsens hospital performance in these areas, as explored below. However, increasing bed capacity by itself – as outlined in the operational resilience plan for the winter of 2021/22⁴¹ – is not sufficient to improve NHS performance; without extra staff to work on those beds, there is a risk of overburdening current staff.

Staff numbers are increasing, but poor retention is hampering progress

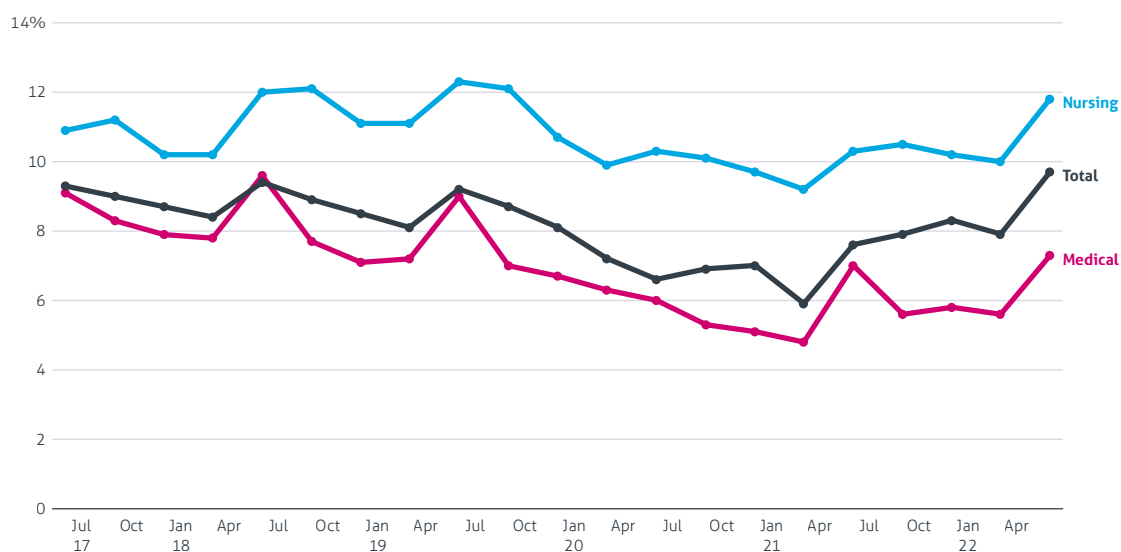
Figure 2.7 Change in doctor and nurse numbers since 2009



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics, Doctors by grade and specialty', May 2022 and 'NHS workforce statistics, Staff group, care setting and level', May 2022, supported by CIPFA. See Methodology for further details.

The number of nurses and doctors increased again in 2021/22, by 4.5% and 2.0% respectively, between May 2021 and May 2022. Since 2019/20, the number of nurses and doctors has increased by 4.2% and 3.4% per year respectively. This compares to a rate of 1.3% and 1.5% respectively between January 2010 and January 2019. This follows the launch of the LTP⁴² in that year, which included ambitions to increase the number of nurses and doctors⁴³ through improved recruitment and retention.

Figure 2.8 Vacancy rates by type of role, June 2017 to June 2022



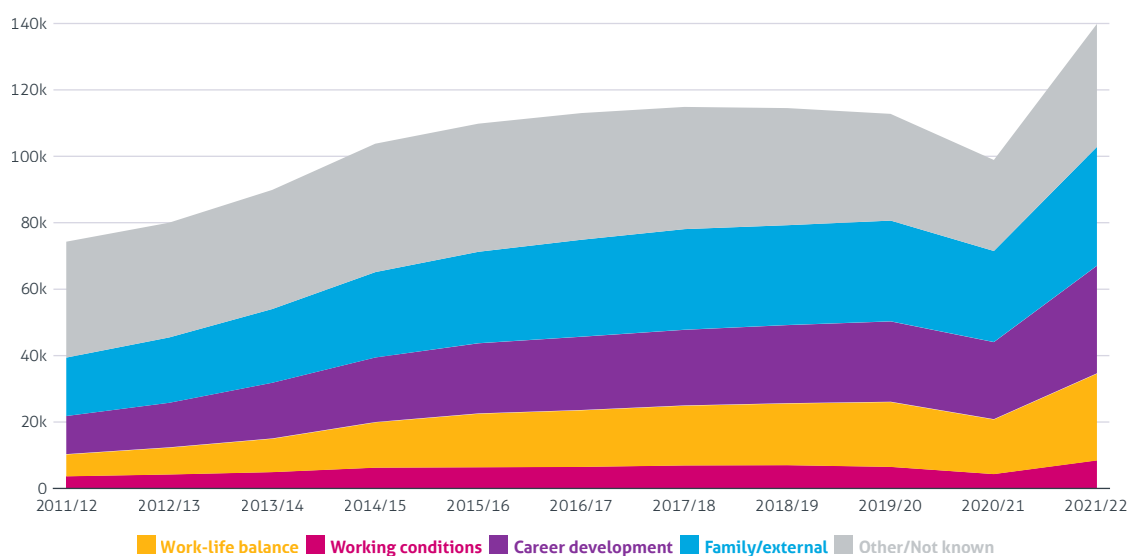
Source: Institute for Government analysis of NHS Digital, 'NHS vacancy statistics England', Tables: Total 2018 onwards, Nursing 2018 onwards, and Medical 2018 Onwards, June 2022, supported by CIPFA. Notes: Data was not published until June 2017.

After a decline in vacancies during the first year of the pandemic, the proportion of unfilled roles in the NHS workforce has increased. In the quarter to the end of June 2022, nursing, medical and total vacancies in NHS providers rose to 11.8%, 7.3% and 9.7% respectively. This total figure is the highest level of vacancies since at least June 2017, when the time series started.

However, these rates hide variation between specialities. For example, in February 2022 the Royal College of Anaesthetists estimated that there was a shortfall of 1,400 anaesthetists across the NHS⁴⁴ – representing an 8.7% vacancy rate, well above the 5.6% vacancy rate for ‘medical roles’ in that quarter (ending March). This is concerning for hospital productivity; anaesthetists are vital for carrying out operations and the same report puts the number of missed operations due to lack of anaesthetists at 1 million per year.⁴⁵

Nursing vacancies are the highest among staff groups, despite increasing numbers of nurses across the service. After dipping before and during the early stages of the pandemic, vacancy rates rose above 10% in 2021/22, reaching a high of 11.8% in June 2022. Overall, the Health and Social Care Committee estimates that there is currently a shortage 50,000 nurses and midwives in England; its figure for doctors is 12,000.⁴⁶

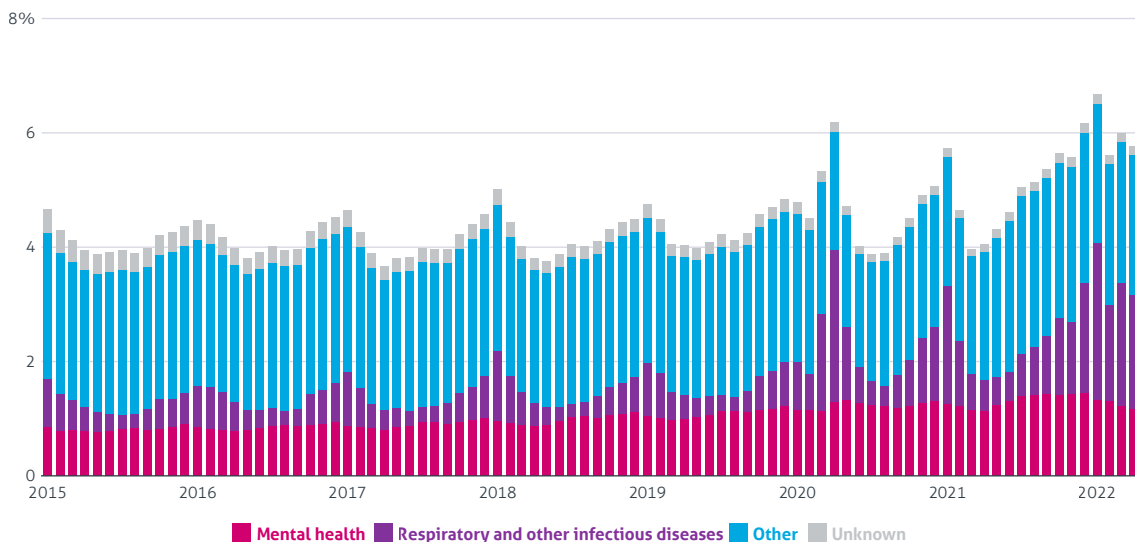
Figure 2.9 **Voluntary resignations by reason, 2011/12–2021/22**



Source: Institute for Government analysis of NHS Digital, ‘NHS workforce statistics, March 2022 reasons for leaving’, Table 1: Reasons for leaving, 2021/22, supported by CIPFA. Notes: Data is not available before 2011/12; see Methodology for further details.

Persistently high NHS vacancy rates are in part due to record levels of voluntary resignations. These grew to 139,862 in 2021/22, up from 98,878 in 2020/21 and 112,787 in 2019/20 – increases of 41.4% and 24% respectively. Of these, the proportion of leavers citing ‘work-life balance’ as the reason for leaving has increased to its highest ever level, at 18.7% of total voluntary resignations.

Figure 2.10 Staff absence by reason, January 2015 to April 2022

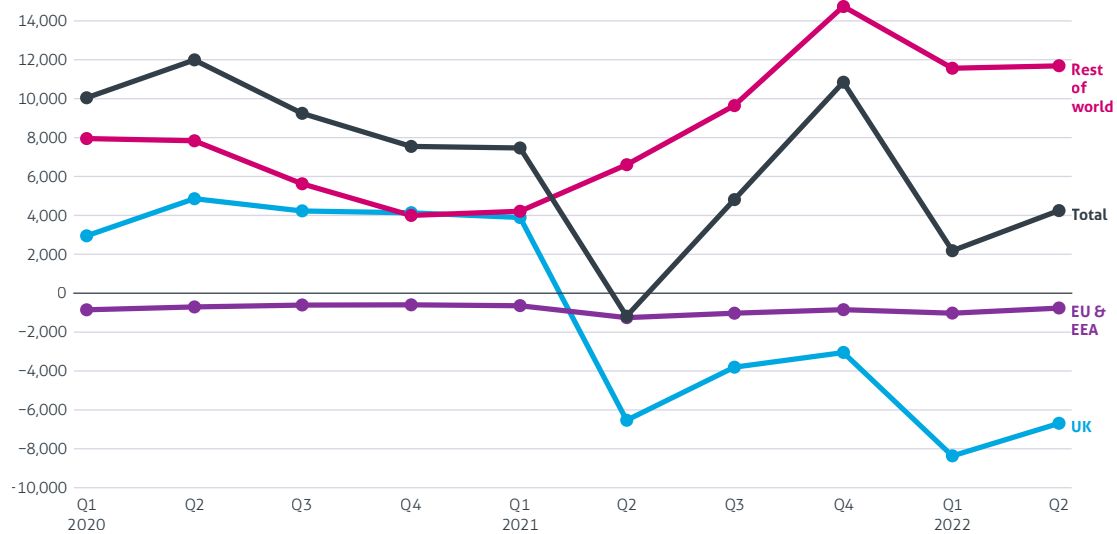


Source: Institute for Government analysis of NHS Digital, 'NHS sickness absence rates', Table 2: Count, April 2022, supported by CIPFA. Notes: Data was not available until 2015; see Methodology for further details.

Worsening retention reflects the pressure that many staff experienced during the pandemic. The proportion of sick days for mental health reasons rose as a percentage of total sick days between February 2020 and August 2020, from 25.6% to 32.5%. One interviewee described the mental health crisis in hospitals as a "vicious cycle", wherein staff resign due to stress and burn-out, which in turn applies more pressure to remaining staff.⁴⁷ The NHS also continues to experience a high number of staff absences due to cold, cough, flu, chest and respiratory problems, and infectious diseases, showing the ongoing effect of Covid on the hospital workforce.

The NHS is filling staffing gaps with agency staff and overseas recruitment, but both solutions come with problems. Agency staff are likely to be more inefficient as they work in unfamiliar teams, areas and roles⁴⁸ and also cost more per shift than regular staff.⁴⁹ The NHS is trying to reduce the amount spent on agency staff.⁵⁰ Reliance on agency staff also risks cannibalising the workforce of other hospitals, shifting staffing problems to another part of the NHS.⁵¹

Figure 2.11 **Rolling 12-month average of net nurse and health visitor joiners and leavers, by nationality, Q1 2020 to Q2 2022**



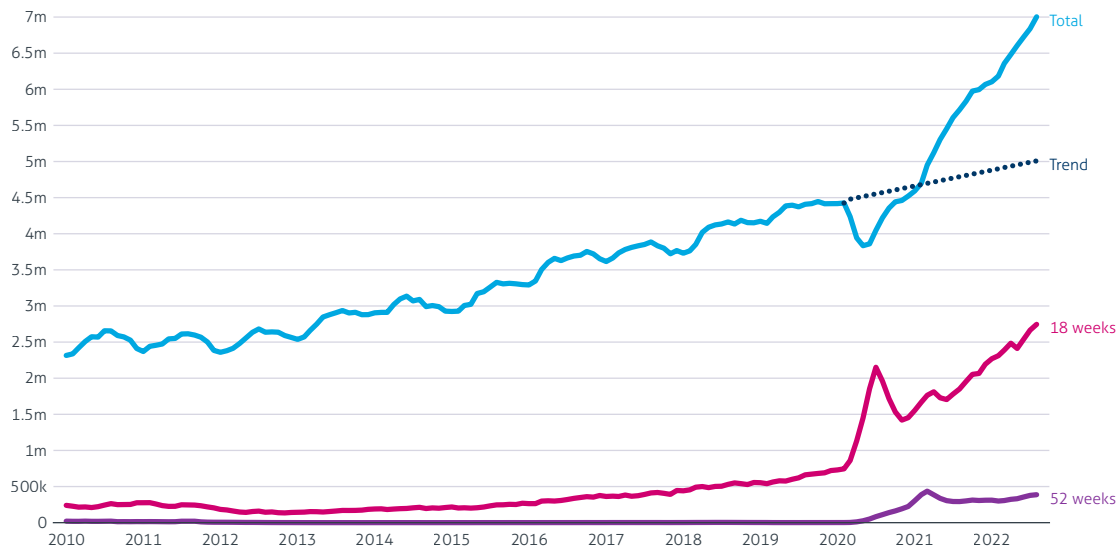
Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics – turnover tables', Table: Leavers, age & nationality and Table: Joiners, age & nationality, March 2022, supported by CIPFA.

Since April 2021, more British nurses have left the NHS than have joined. In their place, the NHS hired more nurses than ever from outside of the UK and the EU/EEA. Recruitment costs of foreign nurses are generally lower than those trained in the UK⁵² but the government has no control over the number of nurses trained abroad and is likely to face greater competition for those nurses in the future as more OECD countries' nursing workforces are increasingly staffed by foreign nurses.⁵³

Uncompetitive pay in the NHS is also worsening retention. This has been exacerbated by two key factors. First, the UK's tighter post-pandemic labour market has caused employers in competing sectors – such as retail and hospitality – to offer better pay deals, including welcome bonuses and higher hourly wages in an attempt to attract in-demand employees.⁵⁴ Second, high and rising inflation is eroding the real value of employees' pay. The government has recognised this and in July 2022 – one month after the most recent vacancy data – accepted the NHS pay review bodies' recommendations for a pay uplift in full,⁵⁵ which will increase the NHS's wage bill "by almost 5% in 2022/23", with the highest uplifts going to the bottom of the wage distribution.⁵⁶ The pay increase, however, is unfunded by central government, meaning that the money will have to come out of the existing NHS settlement. The King's Fund estimates that this could cost the NHS an extra £1.6bn–£2.4bn.⁵⁷

The elective backlog has grown, but is smaller than expected

Figure 2.12 Elective waiting list length, total and by length of wait, January 2010 to August 2022



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times', August 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

By August 2022, the elective backlog had surpassed 7 million people for the first time. People are also waiting longer for procedures. The proportion of the waiting list seen within 18 weeks of referral from a GP fell to 60.8%, its lowest level outside of the first months of the pandemic and far below the NHS's target of 92%.⁵⁸ And 2021/22 is the first time that patients have waited more than two years for treatment since at least 2010, with 2,646 people still in this category by the end of August. But while Covid worsened wait times for elective surgery, it is not the root cause for them increasing. The last time that the NHS met the 18-week target was in February 2016. This is due to a combination of rising demand for services and underinvestment in the beds and staff that would have been needed to meet that demand.⁵⁹

Though the backlog is the longest it has ever been, there is also evidence that more people than are currently on waiting lists should have come forward for care. In December 2021, the Institute for Fiscal Studies (IFS) estimated that 7.6 million fewer people than expected joined a waiting list for hospital care during the pandemic.⁶⁰

There are several possible explanations for this. First, is a change in patient behaviour.⁶¹ While the NHS might have wanted to encourage people to come forward for care after the initial Covid wave,⁶² government messaging – for example, "Stay at home, protect the NHS, save lives" – portrayed the NHS as under immense pressure.⁶³ This might have led to fewer people coming forward for care.

Second, and most importantly, there are now higher barriers to care at each stage of the referral process than before the pandemic. Our GPs chapter outlines the unprecedented demand for primary care services, which means that it is now more difficult to book a GP appointment than it was before the pandemic. The rate at which GPs refer patients through to secondary care has also dropped, in line with guidance from NHS England.⁶⁴ Interviewees told us that, once referred, hospitals are now more likely to reject referrals that they do not believe need treatment.^{65,66}

The results of limiting access to the elective waiting list are mixed. On one hand, keeping people who do not need care away from an already overstretched system helps hospitals, freeing up capacity to meet emergency and Covid demand. The conditions that would have previously led to admission on to the waiting list, however, do not go away. Instead, patients seek care elsewhere, mainly in primary or social care.⁶⁷ So while this protects hospitals it places a greater burden on services struggling with demand pressures and creates a 'hidden backlog' of care, while keeping the elective waiting list artificially low. This is despite a supposed increased focus on improving health outcomes through early intervention and prevention.⁶⁸ There is also the risk that the longer would-be patients stay away the worse their condition becomes – meaning that when they do present, treatment could be more complex and expensive.

The NHS was very close to meeting the first – but most achievable – of its backlog recovery targets

NHS England launched its Covid backlog recovery plan in February this year.⁶⁹ This plan includes measures such as the separation of elective from urgent activity to prevent surges in demand reducing elective activity, investing in community diagnostic and surgical hubs, increasing bed capacity, moving patients between trusts, and use of the independent sector, among others.

The NHS has already implemented some of these. By April 2022, the NHS had opened 77 community diagnostic centres across England.⁷⁰ According to the government these centres are able to conduct an extra 30,000 medical tests of various types per week (or 1.6 million tests per year), and had already carried out an additional 1 million CT, MRI, ultrasound and endoscopy tests by May 2022.⁷¹ Despite this, the NHS carried out 328,000 fewer diagnostic tests in 2021/22 than in 2019/20 (22.9 million down from 23.3 million).

The elective backlog recovery plan also lays out the NHS's timetable for reducing the waiting list:

- Eliminate waits of more than two years by July 2022
- Eliminate waits of more than 18 months by April 2023
- Eliminate waits of more than one year by March 2025.

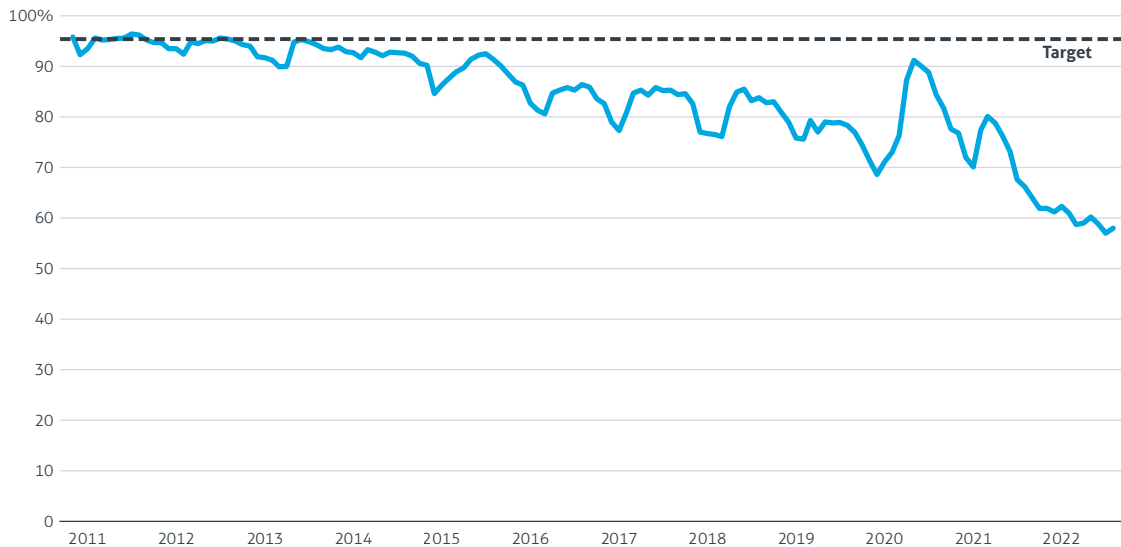
According to NHS England, it nearly met the first of these targets. By the end of July, 2,885 people who had been on the elective waiting list for more than two years were still awaiting treatment, down from 23,778 in January of the same year.⁷² There are, however, some caveats that NHS England make to these outcomes: of those 2,885 remaining on the waiting list, 1,579 opted to defer treatment and 1,030 were "very complex cases".⁷³

The other targets will prove even harder to meet. There are far more people waiting 18 months or a year – and the NHS will not know who the latter group are until April 2024.⁷⁴ This means it does not yet know the types of procedure that will be needed to meet the target, making it harder to plan resource use.

It is not clear the planned measures to clear the backlog will work, as they are highly contingent on the extent to which Covid continues to impact the NHS.⁷⁵ The NHS estimates that it needs to operate at 130% of pre-pandemic activity levels by 2024/25 to clear the elective backlog,⁷⁶ but in 2021/22 was not yet running at 100% of 2019/20 activity, with completed pathways (admitted and non-admitted) at only 92.7% of the amount carried out in that year.

Performance of emergency and acute services is the worst on record

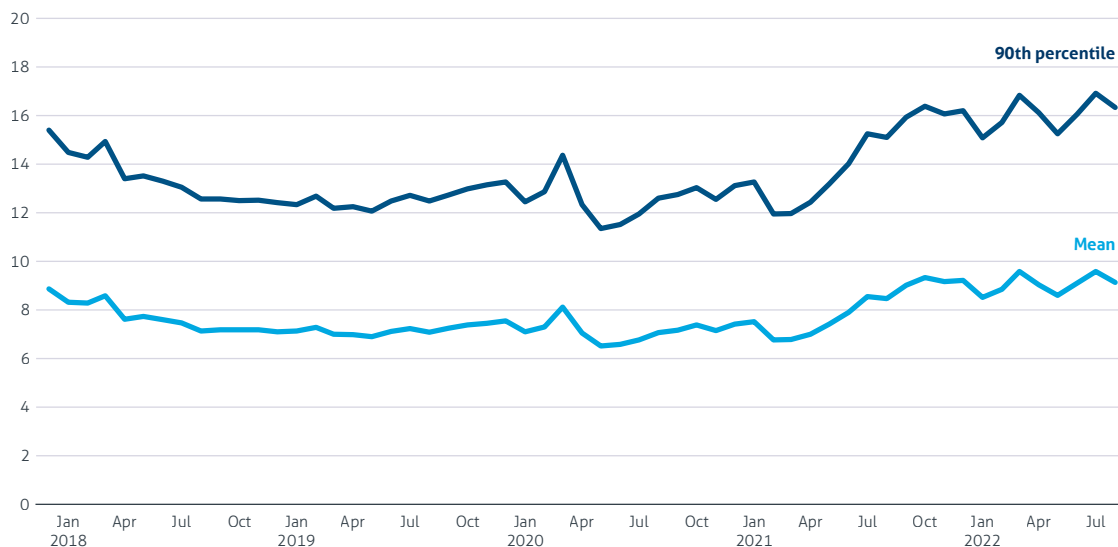
Figure 2.13 **A&E attendances seen within four hours, November 2010 to August 2022**



Source: Institute for Government analysis of NHS England, 'A&E attendances and emergency admissions', Table: Performance, August 2022, supported by CIPFA. Notes: These are waiting times for type 1 A&E departments.

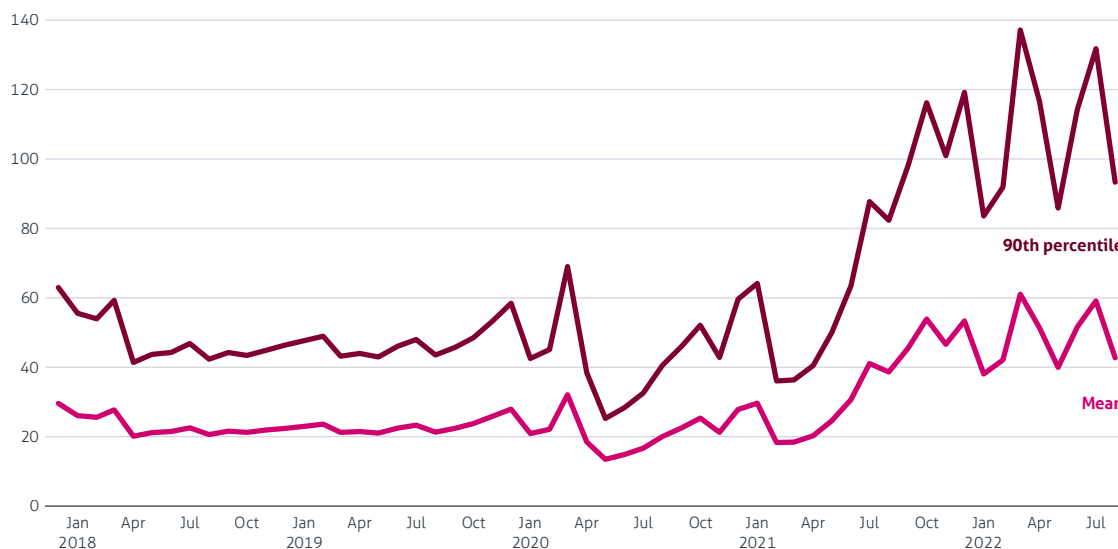
After a slight improvement in A&E wait times during the pandemic (mostly because fewer people attended emergency departments), only 57% of people attending type 1 A&Es were seen within four hours in July 2022, against a target of 95% – the lowest proportion on record. The same decline in performance is evident in the ambulance service, with response times at their highest recorded level. In July 2022, the mean response time for C1 ambulance incidents – the most urgent ambulance response category – rose to 9 minutes 35 seconds, the worst on record. The decline in performance is even worse for category 2 ambulance call-outs – a category that includes conditions such as strokes⁷⁷ – where the mean response time has risen from 22 minutes 33 seconds in July 2018, to 59 minutes 7 seconds in July 2022.

Figure 2.14 **Response times in minutes for category 1 ambulance incidents, December 2017 to August 2022**



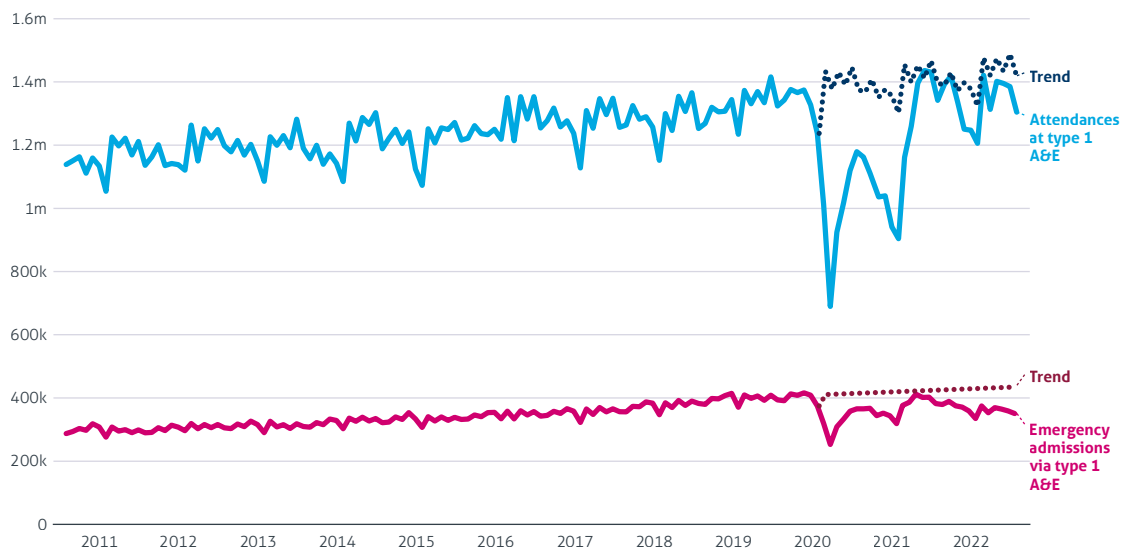
Source: Institute for Government analysis of NHS England, 'Ambulance quality indicators time series', Table: Response times, August 2022, supported by CIPFA. Notes: 90th percentile is the time at which 90% of response times were faster than this, and 10% were slower; category 1 responses are for the most severe calls that include a life threatening condition, such as cardiac or respiratory arrest; data was not available before 2017.

Figure 2.15 **Response times in minutes for category 2 ambulance incidents, December 2017 to August 2022**



Source: Institute for Government analysis of NHS England, 'Ambulance quality indicators', Table: Response times, August 2022, supported by CIPFA. Notes: 90th percentile is the time at which 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 was not available before 2017.

Worsening performance in urgent and emergency care cannot be attributed to a post-pandemic surge in demand for this service. Attendances are up, but not by much. There were 16.1 million attendances at type 1 A&Es in 2021/22 compared to 15.8 million in 2019/20, an increase of 1% per year over the two years. This compares to an annual increase of 1.3% between 2011/12 and 2019/20.

Figure 2.16 **Attendances and admissions in type 1 A&Es, August 2010 to August 2022**

Source: Institute for Government analysis of NHS England, 'A&E attendances and emergency admissions', Table: Activity, August 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Rather than increased demand, the major problems with urgent and emergency care relate to capacity. As with elsewhere in the hospital service, A&E departments are still experiencing staffing issues, both related and unrelated to Covid.⁷⁸ More vacancies and staff absences mean that many shifts are understaffed, which in turn reduces the number of patients seen.⁷⁹ This reduces the flow through A&E and increases wait times.

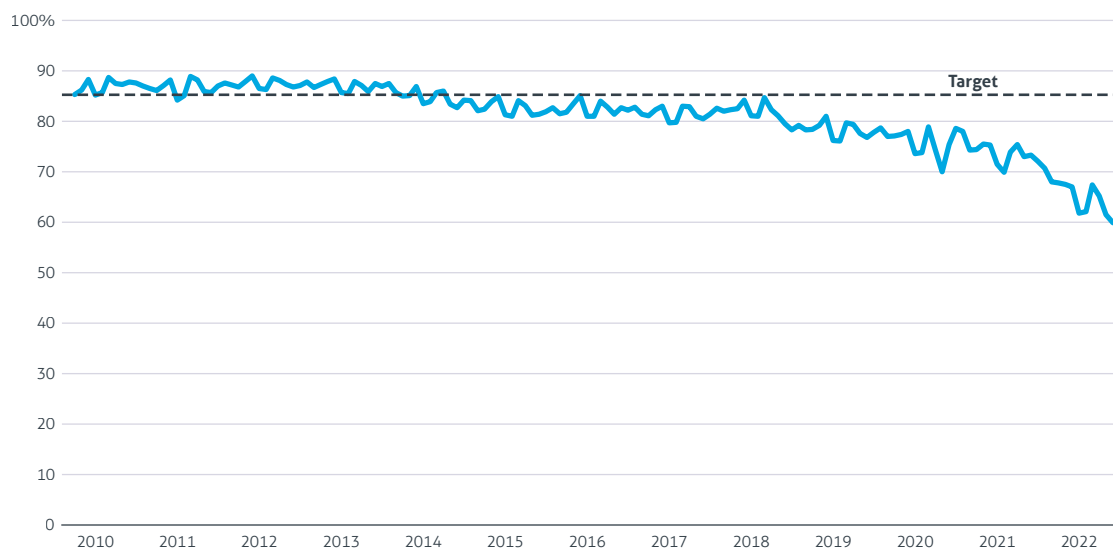
Most importantly, pressure elsewhere in hospitals has a knock-on effect on the performance of urgent and emergency care.⁸⁰ When staff eventually see people, they find it difficult to admit patients due to the lack of unoccupied beds in hospitals noted above. This has resulted in 2021/22 having the lowest percentage of A&E attendances resulting in admissions since 2016/17 – 28.3%, compared to 29.9% in both 2018/19 and 2019/20. This difficulty in admitting patients pushes up the amount of time that people wait in A&Es.

This also explains much of the delay in ambulance response times; ambulances cannot hand over patients for admission into hospitals due to a lack of available beds. This has resulted in the highest proportion of ambulance arrivals resulting in delayed handovers (more than 30 minutes) on record.⁸¹ This in turn prevents ambulances from responding to new calls, thereby increasing response times.

Declining performance in emergency care is extremely serious. Beyond the worsening experience for attendees, there is evidence that those who wait more than five hours are more likely to die within 30 days of attending A&E.⁸²

More people are waiting longer for cancer treatment

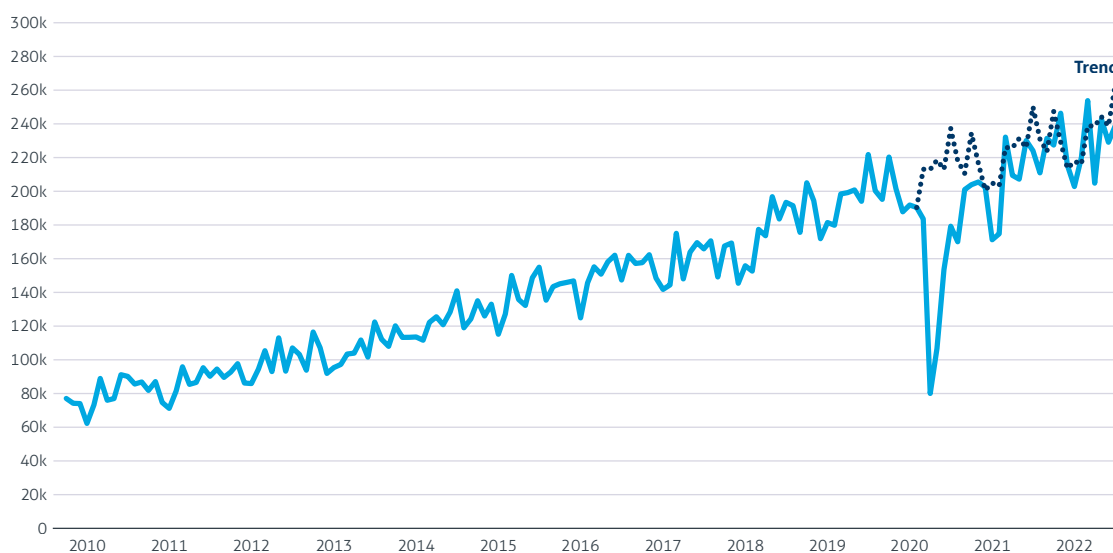
Figure 2.17 **Patients starting treatment within two months of an urgent cancer referral, October 2009 to June 2022**



Source: Institute for Government analysis of NHS England, 'Cancer waiting times', Table: Monthly data – Two month wait from GP urgent referral to a first treatment, June 2022, supported by CIPFA.

The proportion of patients on a cancer referral pathway seen within the targeted 62 days declined again in 2021/22 – from 74.3% in 2020/21 to 68.8%. As with other aspects of hospital performance, increasing cancer wait times predate the pandemic: the last month that the NHS exceeded the 85% target was in December 2015.

Figure 2.18 **Urgent cancer appointments, October 2009 to June 2022**



Source: Institute for Government analysis of NHS England, 'Cancer waiting times', Table: Monthly data – Two week wait from GP urgent, June 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Despite worsening wait times following a cancer referral, the NHS has run a successful campaign to encourage people to come forward for cancer care.⁸³ After a drop in the number of cancer referrals in 2020/21 – down to 2.1 million from 2.4 million in 2019/20 – GPs made 2.7 million urgent referrals in 2021/22.⁸⁴ This equates to an average of 2.4 million referrals per year across 2020/21 and 2021/22, approximately equal to the amount in 2019/20, implying that a good number of the people who did not come forward for care in the early months of the pandemic did so at a later date, and potentially due to the NHS's awareness campaign.

3. Adult social care

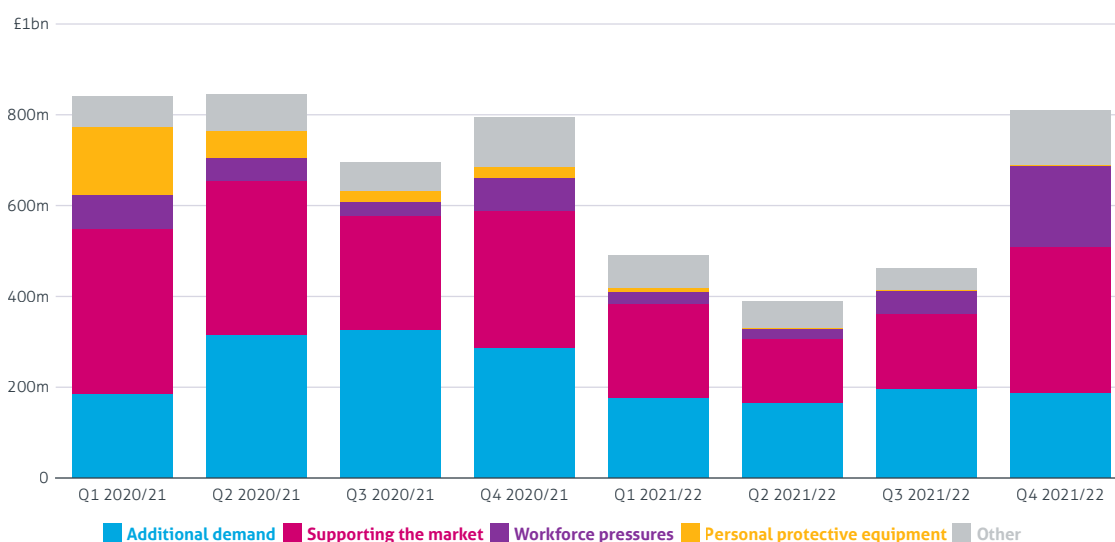
Covid has hit adult social care services hard. In 2020/21, some 39,000 people in residential and nursing homes died from the virus,¹ discouraging older people from coming forward for care.² By the end of 2020/21, both the number of people in long-term nursing and residential care and the number of requests for this care had declined. But there is some indication that demand for care did not go away permanently: 2021/22 saw an increase in the number of people awaiting assessment for care.

At the same time, the workforce crisis that briefly eased during the first year of the pandemic is now worse than ever, with 50,000 fewer posts in the social care workforce filled in March 2022 than at the same point the year before, and the highest vacancy rate on record. This has severe implications for providers' ability to operate effectively. Directors of adult social services report more providers going out of business or handing contracts back, unable to provide enough care to meet demand. This has ripple effects across public services, particularly hospitals and general practice.

The cost of care is also rising, with providers facing a range of inflationary pressures. Central government provided a large package of grants during the first two years of the pandemic, but that support has ended. It is now up to providers and local authorities to meet any funding shortfalls. Where this money will come from is unclear.

Covid-related spending on adult social care totalled £5.3bn over the first two years of the pandemic

Figure 3.1 Pandemic-related local authority spending on adult social care, 2020/21–2021/22



Source: Institute for Government analysis of Department for Levelling Up, Housing and Communities (DLUHC), 'Local authority COVID-19 financial impact monitoring information, rounds 1–20', supported by CIPFA.

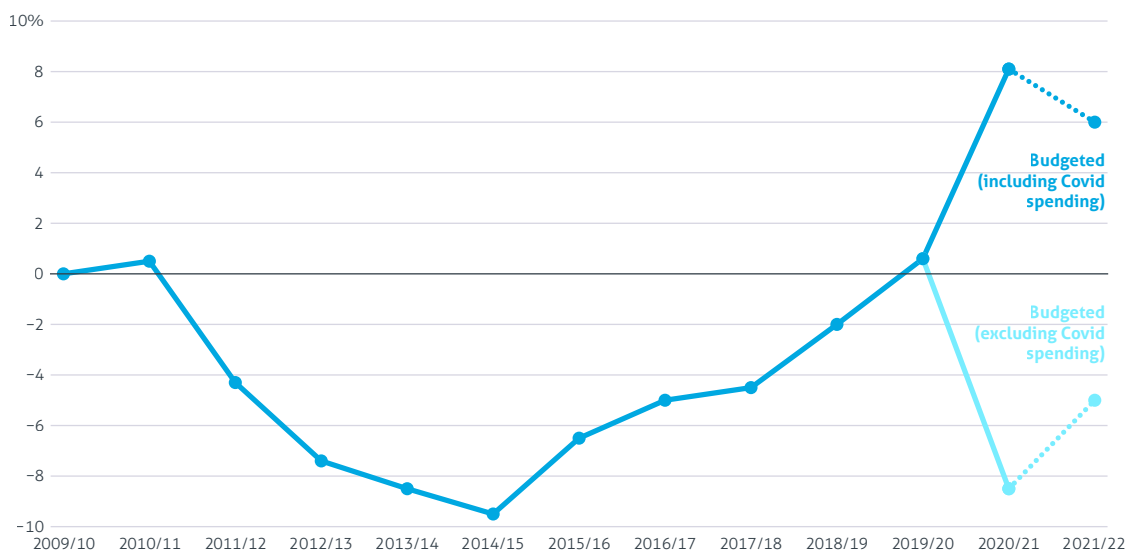
Local authority Covid-related spending on adult social care amounted to £5.3 billion over 2020/21 and 2021/22, with spending falling from £3.2bn in 2020/21 to £2.2bn in 2021/22. Spending on workforce pressures was the only category to increase over the same time period, rising from £231.6 million to £282m, an increase that reflects worsening workforce retention in the second year of the pandemic, discussed further below. This money was spent on a range of initiatives such as supporting payments to increase hours worked, local recruitment initiatives and the hiring of local authority social services staff.³

Spending on 'supporting the market' – money to prevent providers going out of business – made up the largest proportion of spending in both years, at 39.5% and 39% respectively. The Care Quality Commission (CQC) found that this funding largely achieved its intended purpose, with fewer-than-expected providers closing or handing contracts back as a result of support funding.⁴ But it also found that some providers benefited more than others from emergency funding, with home care providers in particular seeing "stable or improved profit margins over the course of 2020/21".⁵ The end of this funding in March 2022 raises questions about market sustainability, as discussed below.

Grants from central government mostly funded the additional spending. This money was provided as a mixture of un-ringfenced grants that could be spent at the discretion of local authorities and grants intended for specific purposes.⁶ For adult social care, the latter category included grants such as the adult social care Infection Control Fund (worth £2.1bn over 2020/21 and 2021/22),^{7,8} the Workforce Capacity Fund for adult social care (£120m in 2020/21)⁹ and the Workforce Recruitment and Retention Fund for adult social care (£462m in 2021/22).¹⁰

Central government support has driven spending increases during the pandemic

Figure 3.2 Change in spending on adult social care since 2009/10 (2021/22 prices)



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report, England 2020-21', Appendix B, Table 5 and DLUHC, 'Local authority Covid-19 financial impact monitoring information, rounds 1-20', supported by CIPFA.

The amount the government spent on adult social care increased by 7.4% in real terms between 2019/20 and 2020/21 (and by 8.1% between 2009/10 and 2020/21). The majority of this increase came from additional local authority spending on adult social care, financed mostly by central government grants that were designed to support both social care users and providers during the pandemic.¹¹ This additional spending amounted to £3.2bn of the £20.7bn spent on adult social care in 2020/21. This was an overestimate of the additional adult social care costs that local authorities would incur during the pandemic and, as a result, councils spent less of their core funding on care than in the previous year. This was not necessarily intentional, but instead a result of rolling forward previous forecasts due to a lack of available data.¹² This overestimation – along with similarly pessimistic forecasting in other local authority-provided services – resulted in local authorities increasing their usable reserves in 2020/21, despite Covid pressures.¹³

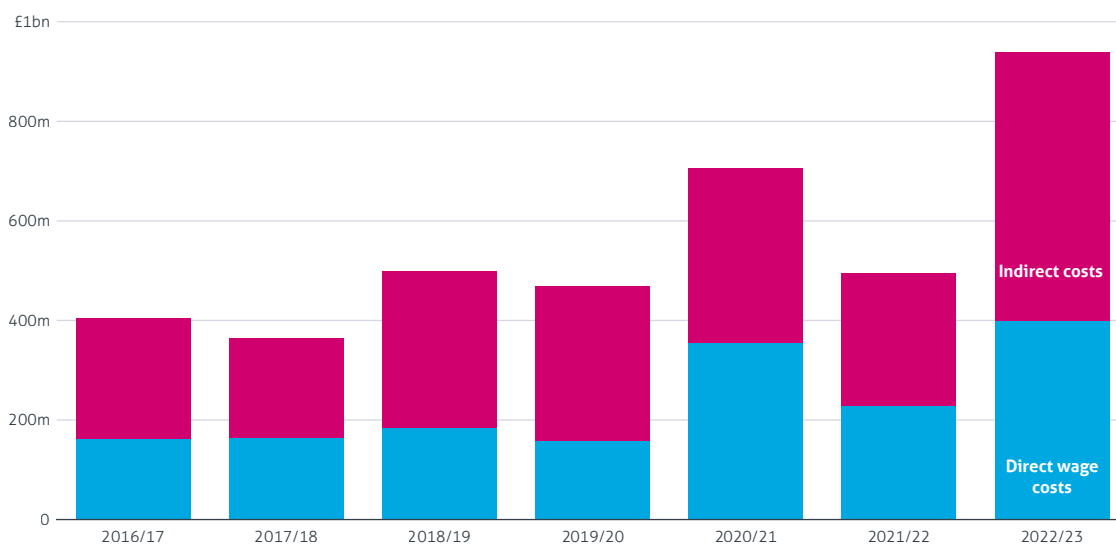
Adult social care spending was budgeted to be 0.4% lower in 2021/22 in real terms than the actual spend of £20.7bn in 2020/21, although this would still represent an increase of 5.4% in real terms, compared with 2019/20. This level of spending is unlikely to be sustainable, given the pressures on adult social care, with evidence that even the current level of funding is not enough to meet existing pressures.¹⁴

Reduced support and rising costs will put pressure on local authority and provider finances

Central government emergency Covid support to local authorities ended in March 2022,¹⁵ although Covid pressures persist in adult social care. While not as burdensome as during the first two years of the pandemic, there is still a need for increased infection prevention and control, although it is difficult to estimate how much this costs providers.^{16,17}

The national living wage (NLW) rose 6.6% in April 2022 and other, non-NLW, wages will also need to rise to improve the recruitment and retention of staff in a tight labour market.¹⁸ Other than wages, providers and local authorities now need to spend more to meet rising inflation and costs, such as fuel – be that for travelling between clients¹⁹ or for heating care homes – and food.^{20,21}

Figure 3.3 **Cost to local authorities of changes in the national living wage, 2016/17–2022/23 (2021/22 prices)**



Source: Institute for Government analysis of ADASS, 'Spring budget survey 2022', supported by CIPFA. Note: 2016/17 was the first year in which ADASS published this estimate.

All of these cost pressures are in addition to the extra money that local authorities need to implement the social care reforms that the government announced in 2021.²² The government has set aside £3.6bn to support reforms of social care charging, including the cap on care costs, the more generous means test for publicly funded social care and the introduction of the "fair cost of care"^{*} for the three years 2022/23 to 2024/25.²³ Yet many doubt these funds will be enough. A report from the County Councils Network estimates that the cost of reforms to social care authorities could be

* The FCC is part of the Johnson government's adult social care reform package announced in September 2021. This measure aims to improve the stability of the social care market after the implementation of section 18(3) of the Care Act 2014, which will end self-funders – those who pay for their own care – having to pay more for care than those whose care is purchased by local authorities on their behalf. Local authorities will meet the shortfall in funding that this will create for providers. They will now pay a 'fair' amount for the care they purchase, to cover providers' costs and allow for some profit. (See Department of Health and Social Care, 'Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023', 16 December 2021, retrieved 30 September 2022, www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023/market-sustainability-and-fair-cost-of-care-fund-purpose-and-conditions-2022-to-2023)

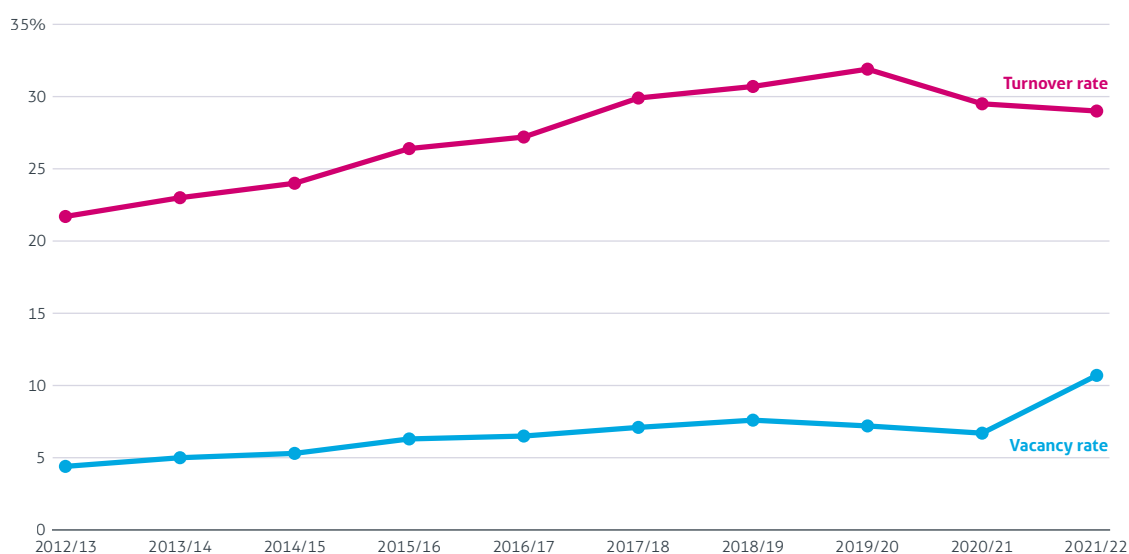
£10bn more than the government's impact assessment suggested²⁴ over the first nine years.²⁵ Due to concerns about the cost burden on local authorities, the government decided to delay the implementation of section 18(3) of the Care Act for those already in residential care until April 2025.²⁶

The spring statement 2022²⁷ made clear that there would be no additional support for public services beyond what was announced in the 2021 spending review.²⁸ As discussed in more detail in the Neighbourhood services and Cross-service analysis chapters, it is now unlikely that total local authority funding will be enough to meet increased demand and rising inflation, let alone the implementation of the reform package described above.

Providers are already feeling the dual effects of increasing cost pressures and reduced support from central government (among other factors): 67% of councils reported that care providers had gone out of business or handed contracts back in the six months to March 2022, compared with 25% in the six months to March 2020.²⁹ Local authorities may struggle to continue supporting the market without additional resources from central government.

Care worker vacancies fell during the first year of the pandemic, but are now on the rise

Figure 3.4 **Vacancy and turnover rates for the adult social care workforce, 2012/13–2021/22**



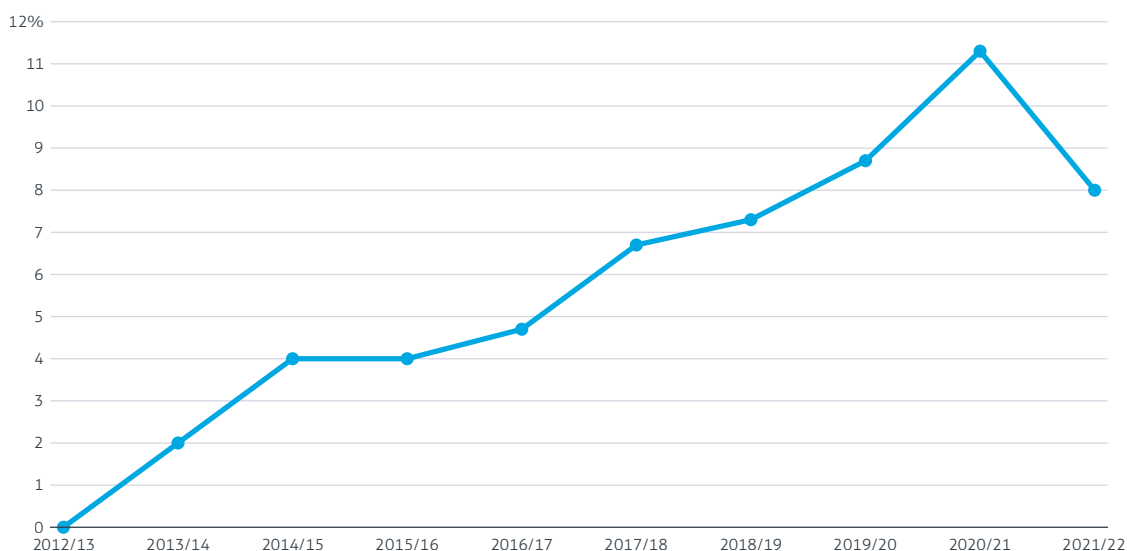
Source: Institute for Government analysis of Skills for Care, 'State of the workforce', 2020/21 and Skills for Care, 'Size and structure of the workforce', 2021/22, supported by CIPFA. Note: 2012/13 was the first year in which Skills for Care published this data.

During the first year of the pandemic, both the turnover rate and the vacancy rate among social care workers fell, following patterns seen across other public services. But this trend reversed from April 2021 onwards,³⁰ with the annual vacancy rate reaching 10.7% in 2021/22³¹ – the highest level it has been since the beginning of the Skills for Care time series in 2012/13.

There were 50,000 fewer filled posts in the social care workforce in March 2022 compared with March 2021

The rise in the vacancy rate was the result of people leaving the adult social care workforce. The number of filled posts in the social care workforce decreased by 50,000 between March 2021 and March 2022, from 1.67 million to 1.62 million.³² This included 35,000 fewer carers. This reduction of the workforce has severe implications for the functioning of the service. Having fewer carers restricts the supply of social care, which in turn makes it harder to place people in care.

Figure 3.5 **Change in the size of the adult social care workforce since 2012/13**



Source: Institute for Government analysis of Skills for Care, 'State of the workforce, 2021/22', supported by CIPFA. Note: the time series does not start in 2009/10 because Skills for Care revised its methodology for measuring the adult social care workforce in 2020/21 and only revised data from 2012/13 onwards.

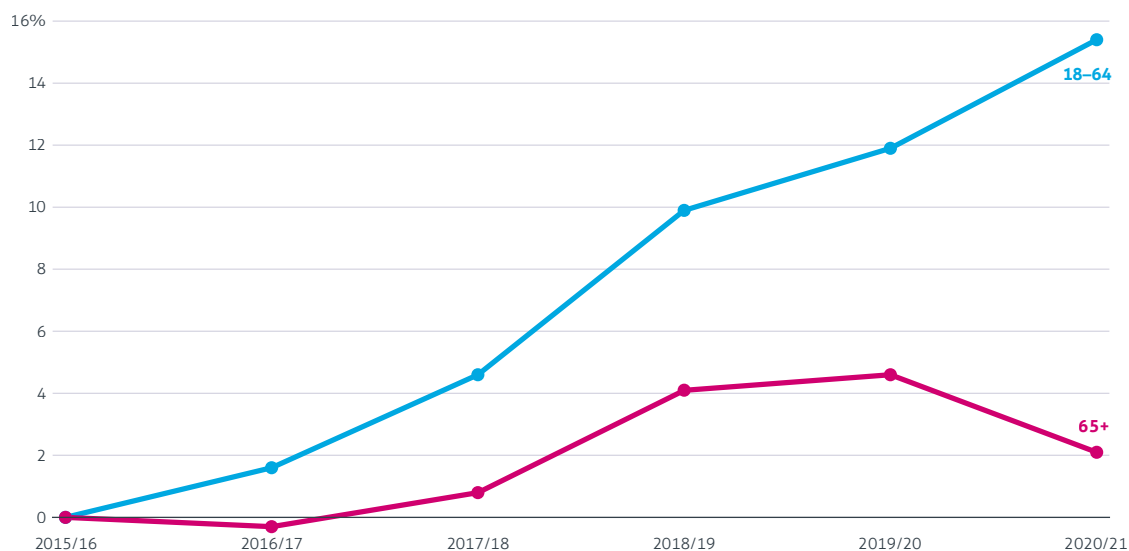
A range of factors is driving the exodus of the adult social care workforce. First, care workers were under immense pressure during the first two years of the pandemic and many suffered burn-out due to "chronic stress",³³ causing them to leave for less-intense jobs. Second, approximately 7% of the adult social care workforce comes from the EU,³⁴ but Brexit has made it harder for EU citizens to work in the UK.³⁵ Third, social care offers few opportunities for training or progression³⁶ – factors that encourage people to stay in the sector³⁷ – in comparison with other careers. Fourth, the government mandated vaccination against Covid for all care home workers from November 2021.³⁸ Unwillingness to be vaccinated was the second most-cited reason among care home staff for leaving the workforce in December 2021.³⁹ Finally, carers are paid poorly compared with workers in other sectors. For example, in 2020/21, the median sales and retail assistant earned 21p more per hour on average than the median care worker.⁴⁰ Adult social care also competes for workers with the NHS,⁴¹ which often pays health care assistants and porters more than care workers.⁴²

This workforce crisis comes in the wake of repeated calls for the government to design and implement a long-term workforce strategy.^{43,44,45} The Department of Health and Social Care committed to producing a workforce strategy in 2018, after recommendations from the National Audit Office⁴⁶ and the House of Commons

Committee of Public Accounts,⁴⁷ but failed to do so.⁴⁸ This means there has been no update to the workforce strategy since 2009.⁴⁹ During the legislative process for the Health and Care Act 2022, the government rejected an amendment that would have required it to commit to regular forecasts.^{50,51}

Requests for care from working-age adults grew in the first year of the pandemic but those from the older population fell

Figure 3.6 Change in requests for support from new clients since 2015/16, by age group



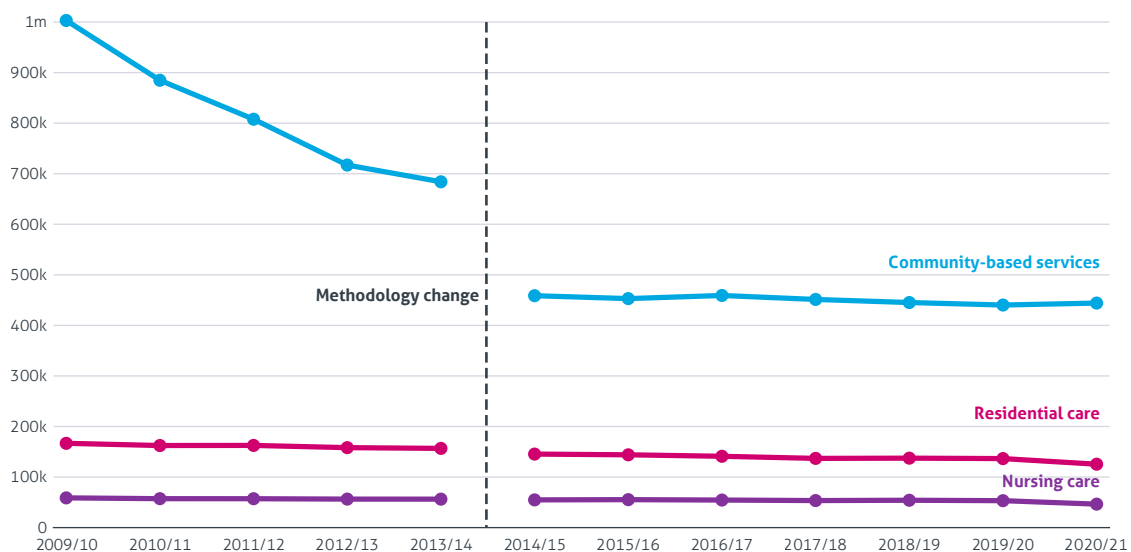
Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2020/21, supported by CIPFA. Note: 2015/16 was the first year that NHS Digital published this information.

Despite a growing population aged 65+, the number of requests for care among this age group fell in 2020/21 compared with 2019/20, down to 1.34 million from 1.37 million. There are a few reasons for this. First, the prevalence of Covid in care homes⁵² and the risk of carers bringing Covid into households, likely discouraged people from seeking residential and home care.⁵³ Second, there is evidence that millions more people provided unpaid care during the first year of the pandemic, as people spent more time at home,⁵⁴ or were unwilling to allow others into their home due to fears about spreading Covid.⁵⁵ This may have depressed demand for local-authority-provided care.

In contrast, the number of working-age adults (aged 16–64) requesting care increased between 2019/20 and 2020/21, from 560,350 to 577,765 – a 3.1% increase. From our interviews, it is unclear what drove this increase, but adult social care directors are increasingly concerned about the financial pressure that rising demand for social care from working-age adults will have on spending, due to this group often having more complex and longer-term requirements than the older population (aged 65+).⁵⁶

The number of people in long-term care declined in the first year of the pandemic

Figure 3.7 Number of people in care at the end of each year, 2009/10–2020/21, by setting



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2020/21, supported by CIPFA.

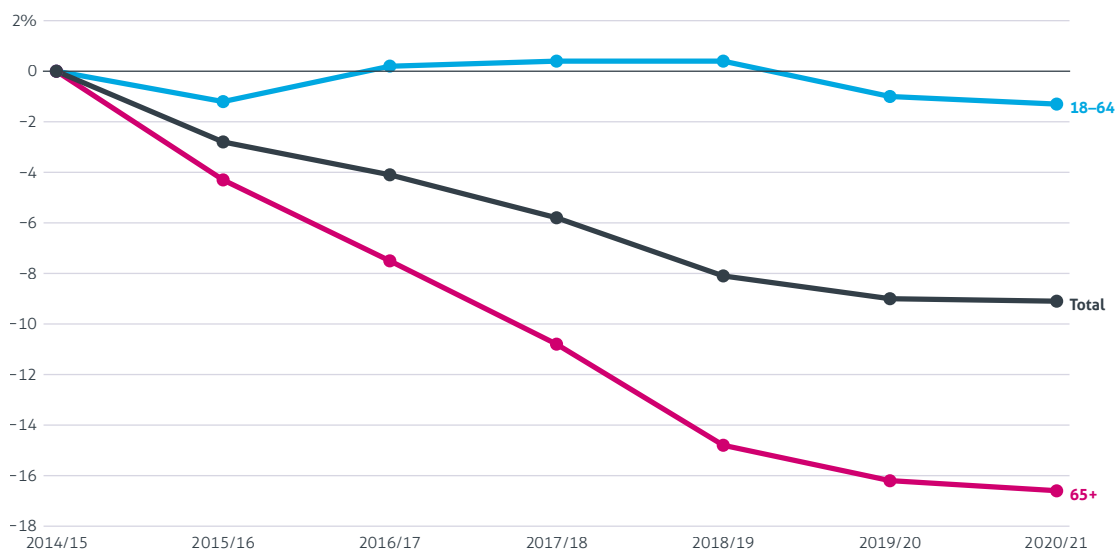
The number of people in long-term care at the end of the year fell from 630,060 in 2019/20 to 616,180 in 2020/21, a 2.2% decline. This decline was not evenly split by care setting. The number of people in community-based care increased by 0.9%, while the number of people in nursing and residential care fell by 12.8% and 8.1% respectively.

High Covid mortality in nursing and residential homes had the dual effect of reducing the number of people in care and likely discouraging people from seeking care in those settings. But the downward trend of people being cared for in nursing and residential settings predates the pandemic. This is due to a combination of government policy – which aims to increase the number of people cared for at home⁵⁷ – and an increase in personal preference for home care among older people.⁵⁸

The proportion of people aged 65+ in long-term care continued to fall in the first year of the pandemic

The proportion of the population aged 65+ in local authority-funded long-term care fell in 2020/21, from 5,297 people per 100,000 population to 5,271 – a 0.5% year-on-year fall and a 16.6% decrease since 2014/15.

Figure 3.8 **Change in people accessing long-term support during the year since 2014/15, by age band**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2020/21 and ONS, 'Mid-year population estimates', 2021, supported by CIPFA. Note: 2015/16 was the first year in which NHS Digital published this information.

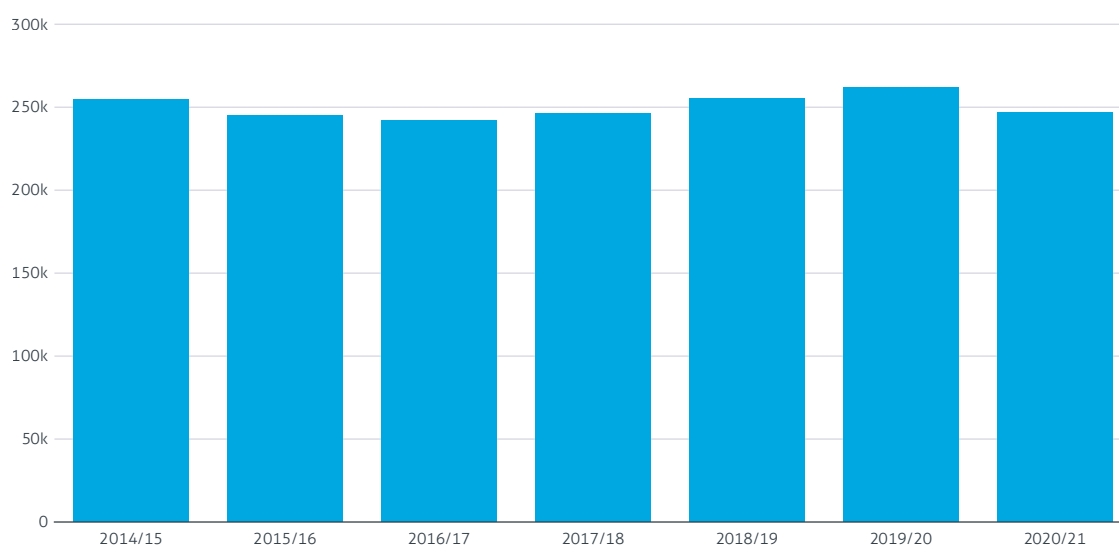
There are a number of explanations for this longer-term shift. First, today, people aged over 65 generally have less need for social care than people of the same age 15 years ago.⁵⁹ Second, cuts in central government grants since 2009/10 have forced local authorities to make tough decisions⁶⁰ and have resulted in many choosing to ration care, which is easier to do for those aged over 65 than for working-age adults, whose needs tend to be greater.⁶¹

Third, because the means test for publicly funded care has been frozen in cash terms, a smaller proportion of people are eligible for it.⁶² Finally, local authorities moved away from being 'care-package factories' that offer social care as the first option,⁶³ to making greater use of 'asset-based' models – such as the 'three conversations' model⁶⁴ – which aim to integrate people into communities by making use of any skills and connections they have. The aim of this approach is to allow people to live fulfilled, independent lives without relying on long-term social care.⁶⁵

But asset-based approaches may not be fulfilling their purpose, for a couple of reasons. First, it could be that local authorities use these approaches as a means of saving money, in the process pushing caring responsibilities on to families, neighbours and the voluntary sector.⁶⁶ Second, there is little evidence about whether these approaches deliver better or worse outcomes.

The number of completed short-term care packages fell in the first year of the pandemic

Figure 3.9 Number of completed short-term care packages to maximise independence, 2014/15–2020/21



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2020/21, supported by CIPFA. Note: 2015/16 was the first year in which NHS Digital published this information.

The number of completed short-term care packages to maximise independence (among both new and existing clients) fell from 261,605 in 2019/20 to 246,600 in 2020/21, a 5.7% decline. As with long-term care packages, this could be because people avoided care where possible due to Covid. Another reason may be that it was easier at the height of the pandemic to discharge people from hospital into nursing or residential care, rather than into short-term settings, which can require more specialised care.⁶⁷ There is also evidence of staff shortages during the pandemic leading to reablement staff – who usually assist people coming out of hospital to regain the skills that will allow them to live independently – working in residential homes, therefore making it harder for local authorities to place clients in short-term care.⁶⁸

It is also worth noting that if local authorities were pursuing an asset-based approach with the aim of facilitating independent living rather than reducing the amount of budget dedicated to adult social care, then we would expect to see increasing levels of short-term care packages to maximise independence. This outcome is not evident from the data.

There are signs of a backlog in social care demand

The decline in activity in adult social care could mean that there is pent-up demand for this care. There is some indication of this already: the Association of Directors of Adult Social Services (ADASS) estimates that as of April 2022, 294,449 people were awaiting assessment for care,⁶⁹ up from 70,000 in September 2021,⁷⁰ with 73,792 of those waiting for more than six months.⁷¹ Part of the reason for this delay in receiving assessments is that the number of social workers – local authority employees who carry out social care assessments, alongside other responsibilities – declined from 17,500 in 2020 to 17,300 in 2021.⁷² While not a large drop (only 1.1%), this does mean that fewer workers are now carrying out a greater volume of work, leading to a bottleneck before people even reach care.

When a social worker assesses a client as being in need of adult social care, often there is no care available for them, due to the workforce⁷³ and cost pressures described above.⁷⁴ This means that people who need care may go without⁷⁵ or seek care elsewhere, not least from unpaid carers.⁷⁶

The reduction in the number of people in care aged 65+, up to 2019/20, despite an increase in the number of requests for care, means it is likely there was substantial unmet demand even before the pandemic. Unmet demand for social care may increase pressures in primary, community and secondary care,^{77,78} although evidence for this is mixed.⁷⁹ It should also be noted that causality between the health and social care systems flows both ways; during the worst of the pandemic, hospitals often discharged patients too early, meaning that they had a higher need for care, putting even more pressure on adult social care.⁸⁰

4. Children's social care

The pandemic has made it more difficult for local authorities to ensure children's safety, exacerbating existing long-term problems facing the sector. During the height of the crisis, limited spare capacity in the residential sector fed into higher costs as authorities sought out accommodation. The number of children in care remained at an all-time high as fewer children could be safely discharged – this is despite referrals to social services falling dramatically, principally during lockdowns.

It is too early to know whether cases that did not get referred will show up or the extent of additional harm suffered by children during this time, though there have been some notably tragic cases. Several highly critical recent reviews have called for radical overhauls of the system to improve the quality of children's social care. This chapter examines 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 'looked-after children', including through foster and residential care placements.

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

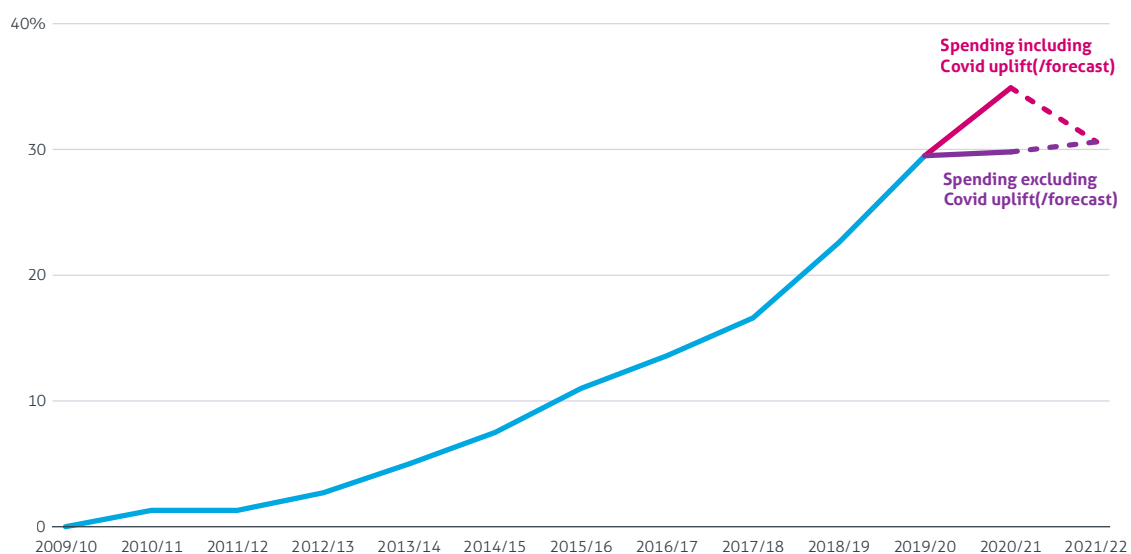
Local authorities spent 10.0£ billion on children's social care in 2020/21, a 34.9% rise in real terms compared to 2009/10.¹ By comparison, the children's population grew by less than 10% over the same period. The sustained increase in children's social care spending continues to squeeze other areas of local government spending.²

Spending has also prioritised children's social care at the expense of other services for children. Spending on safeguarding children and young people's services increased by 25%, and on looked-after children* by 42%, between 2009/10 and 2020/21.³ Over the same period spending on services for young people was cut by 63% – Sure Start children's centres and other spend on children under five fell by 72%.⁴

The government-commissioned independent review of children's social care has called for a roughly £2bn (20% in cash terms) uplift to children's social care spending over the next five years.⁵ It also called for a rebalancing of priorities away from crisis interventions towards earlier stage interventions with an annual amount of £1bn ring-fenced for family help.⁶

* 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.

Figure 4.1 **Change in local authority spending on children’s social care in England since 2009/10 (real terms)**



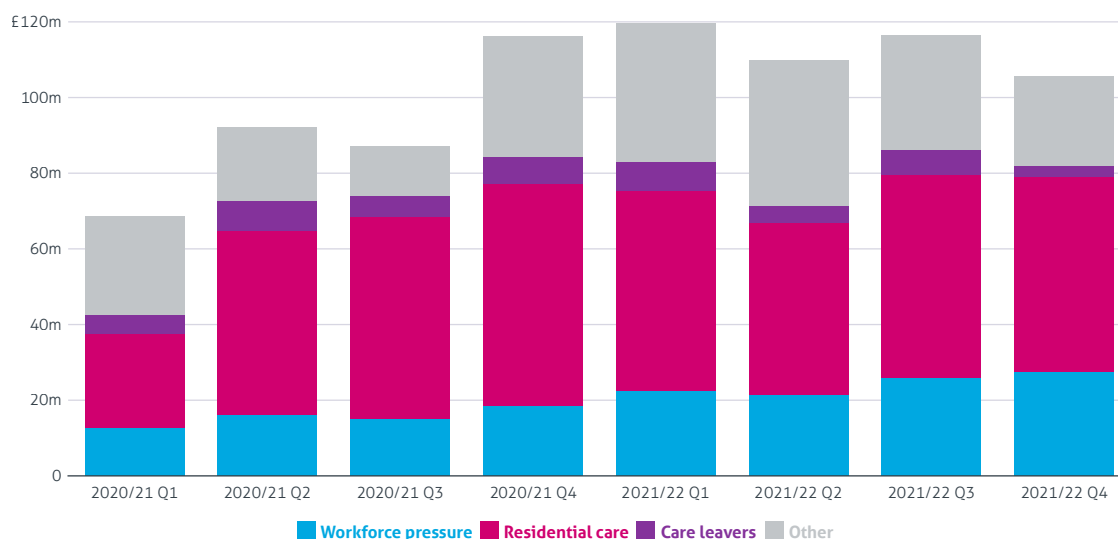
Source: Institute for Government analysis of DfE, 'LA and school expenditure', 'S251 Outturn – Children and Young People’s Services (National, Regional, LA levels)' table, 2009/10-2020/21; DLUHC, 'Local authority revenue expenditure and financing', 'Revenue outturn social care and public health services (R03) 2020–21' table; DLUHC, 'Local authority revenue expenditure and financing', 'Local authority revenue expenditure and financing England 2021 to 2022 budget, England' table; DLUHC, 'Local authority COVID-19 financial impact monitoring information' table, supported by CIPFA. Notes: details on forecasts and spend net of Covid can be found in the Methodology chapter.

Local authorities faced additional pandemic-related children’s social care spend, particularly on residential care

During the 2020/21 and 2021/22 financial years, local authorities spent £820.6 million on pandemic-related social care costs.⁷ Almost half (48%) of these extra costs in 2021/22 were accounted for by the higher cost of residential care placements for children.⁸ The cost of these placements rose sharply during the pandemic due to infection control measures and higher residential staffing costs.^{9,10}

Almost a fifth (19%) of the additional pandemic-related costs – totalling £159.5m during 2020/21 and 2021/22 – came from workforce pressures as local authorities and providers faced higher unit costs from agency staff.¹¹ Local authorities were given support to meet these and other costs through non-ring-fenced grants from central government, though the degree to which Covid-specific funding helped to offset regular children’s social care costs is difficult to assess.¹²

Figure 4.2 **Additional pandemic-related children’s social care spending, 2020/21–2021/22**



Source: Institute for Government analysis of DLUHC, 'Local authority COVID-19 financial impact monitoring information', rounds 1-20, supported by CIPFA. See Methodology for further details.

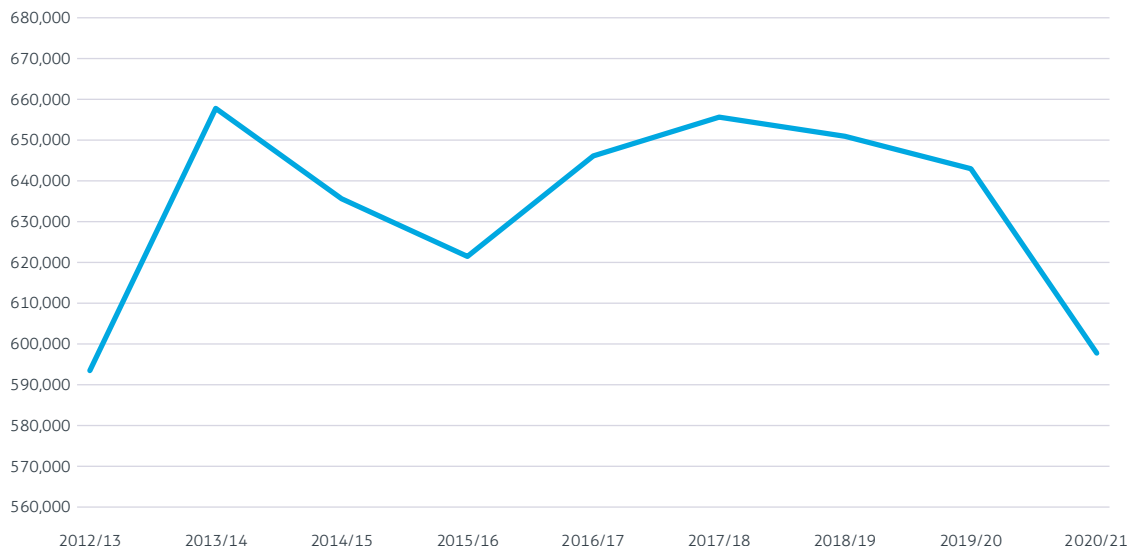
Additionally, the demand for children’s residential places has increased following the 2021 ban on the use of unregulated accommodation,¹³ though the practice still continues in some cases.¹⁴ Overall, despite the number of children’s homes increasing by 184 to 2,776 between August 2020 and 2021,¹⁵ it is likely that capacity was still outstripped by demand.¹⁶ Furthermore, national increases can mask local shortfalls, including in the quantity and quality of secure homes, and in placements for children with complex or challenging needs.^{17,18} These problems predate the pandemic. For example, in 2022 Ofsted analysis showed that as of March 2020 only 5% of homes stated that they could accommodate complex health needs.¹⁹

Higher profits by private residential providers have added to costs facing local authorities, with 83% of all provision in the independent sector.²⁰ This trend was also identified in a recent report by the Competition and Markets Authority, which found private providers were making higher profits through higher prices and provision that did not always meet the needs of children.²¹

Despite fewer children being referred to children’s services, pressures continue in the system

Referrals to children’s social care fell by approximately 45,000 in 2020/21 with 7% fewer referrals compared to 2019/20.²² This was the lowest number of referrals since 2012/13.²³

Figure 4.3 Referrals to children’s social care, 2012/13–2020/21



Source: Institute for Government analysis of ONS 'Characteristics of children in need' reporting year 2021 table C1, 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 fall in referrals is that potentially vulnerable children had less contact with public services during the pandemic. Schools, for example, referred 30.6% fewer cases in 2020/21 than in 2019/20.²⁴

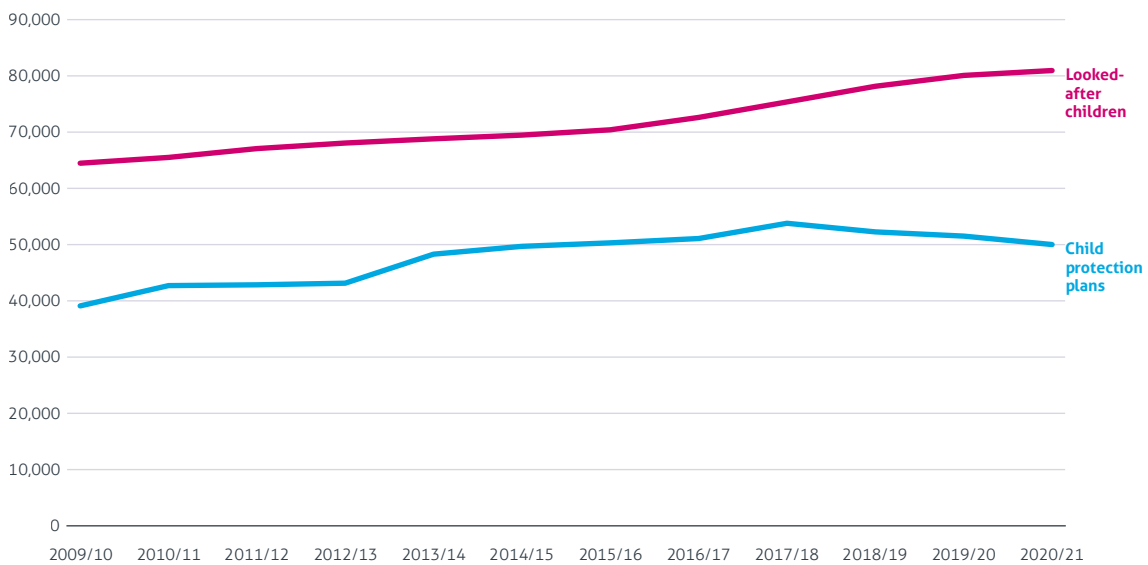
It is unclear whether missing referrals during the pandemic will lead to higher referrals at a later date.²⁵ Referral data for 2021/22 is currently unavailable and the picture remains highly uncertain. Some local authorities responding to a survey by the Department for Education (DfE) reported that, continuing the pre-pandemic trend, the nature of cases coming forward appears to be more complex, which may add pressures to the system.²⁶ A 2022 British Association of Social Workers survey of members also raised concerns that cost of living pressures could lead to unmanageable caseloads.²⁷

The number of children on child protection plans remains high despite falling slightly during the pandemic

For the third year in a row the number of child protection plans (CPPs)* fell in 2020/21 and now stands at around 50,000. DfE analysis shows this is down 2.9% since 2020 and is at its lowest level since 2015.²⁸ The number of CPPs, however, remains significantly higher than the approximately 39,000 plans in place in 2009/10.²⁹

The continued reduction in CPPs may be attributable in part to greater delays in the family courts during the pandemic which increased the time it takes for local authorities to take children into care or other measures such as adoption or moving back to family homes.³⁰

Figure 4.4 Looked-after children and child protection plans, 2009/10–2020/21



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 2021' table and Children looked-after in England including adoption, 2009/10 to 2020/21 'CLA numbers and rates per 10,000 children aged under 18 years – LA' table, supported by CIPFA.

* 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 child protection plan 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.

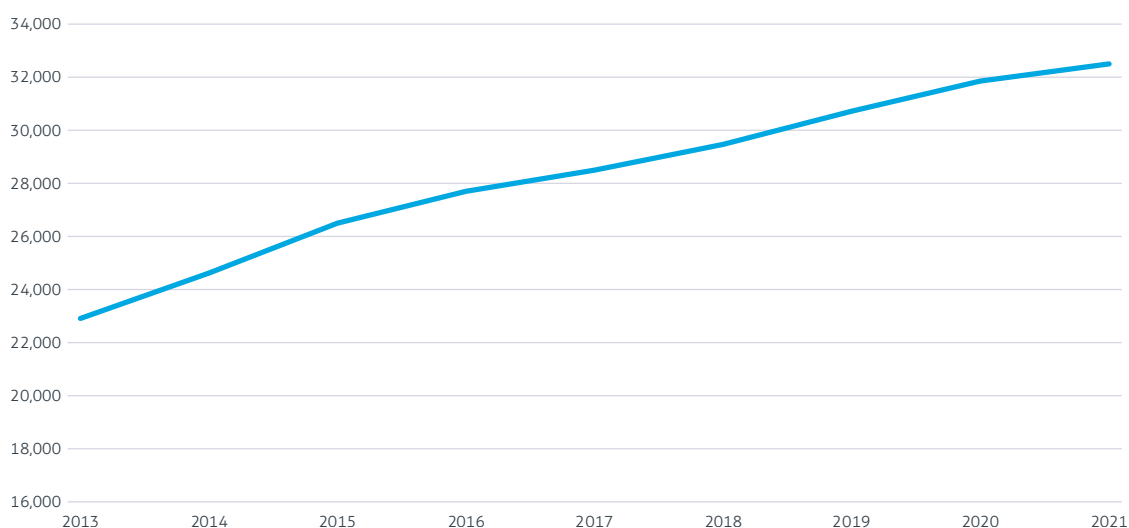
There has been a small increase in the number of children cared for by local authorities

Despite both referrals and serious incident notices falling and fewer children being subject to CPPs, social workers have continued to support a similar volume of 'looked-after-children'* as immediately prior to the pandemic. As of March 2021, there were approximately 81,000 'looked-after children', which was up 1% on the previous year and continues a longer-term rise seen over the past decade.³¹ This is largely due to fewer children leaving care before the age of 18.^{32,**}

Social worker staffing levels continue to rise alongside sustained levels of vacancies

The number of children's and family social workers continued to grow with a 2% increase in 2021/22 but the proportion of vacancies remained steady.³³

Figure 4.5 Children's social workers, full-time equivalent, 2013–2021

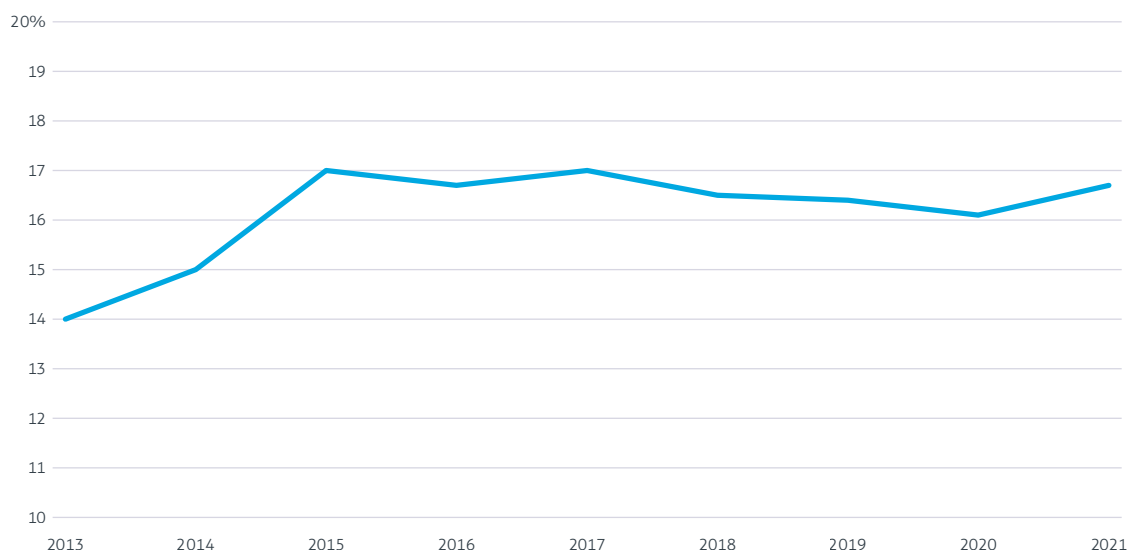


Source: Institute for Government analysis of DfE, 'Children's social work workforce' reporting year 2021, 'Caseloads, absence, vacancies, turnover and agency workers' table, supported by CIPFA. Notes: following a methodology change comparable figures are not available before 2013; figures are as at 30 September of the relevant year.

* A child who has been in the care of a local authorities for more than 24 hours. Generally these children are accommodated in children's homes, residential settings like secure units, or by foster parents.

** It remains unclear what is the key driver of this trend. Multiple explanations have been outlined in DfE, 'Drivers of activity in children's social care' research report, May 2022 (accessed September 2022) available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1080111/Drivers_of_Activity_in_Children_s_Social_Care.pdf, pp. 7–8, 18–24.

Figure 4.6 **Social worker vacancies, 2013–2021**

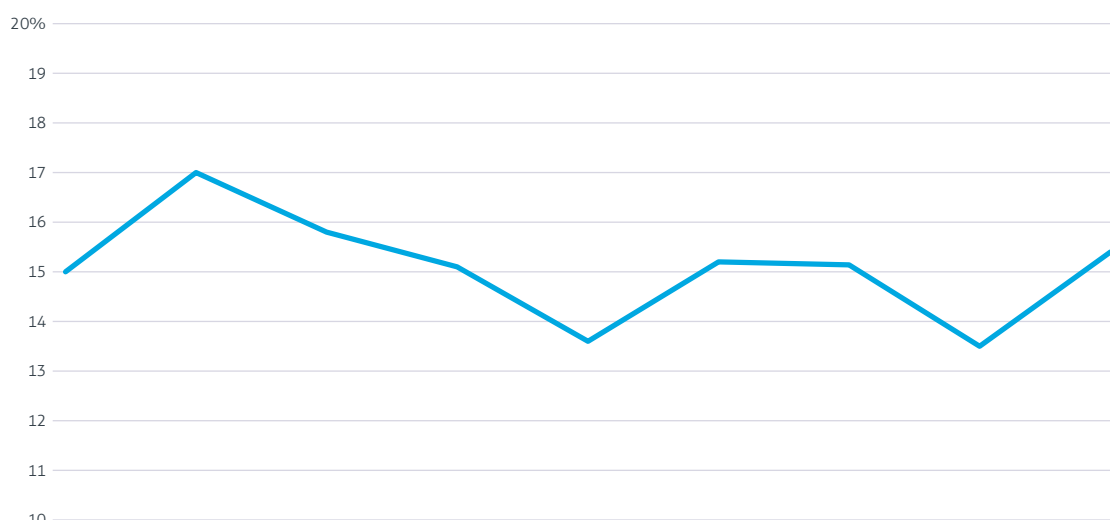


Source: Institute for Government analysis of Department for Education, 'Social work workforce statistics' reporting year 2021, 'Caseloads, absence, vacancies, turnover and agency workers' table, supported by CIPFA. Notes: following a methodology change comparable figures are not available before 2013; vacancy numbers are as at 30 September of the relevant year.

As of 2021/22, staff with less than five years' experience make up 60% of the labour force.³⁴ While there has been some improvement in the proportion of staff with two to five years' experience, rising from 27% in 2020/21 to 29% in 2021/22, a relatively high proportion of staff (31%) have under two. This could affect the quality of children's social care services. As *The Independent Review of Children's Social Care* highlighted in May 2022, social work requires experienced, knowledgeable and skilled workers to make difficult and sensitive decisions.³⁵ Yet the review noted that social work is often carried out by relatively inexperienced and early career staff who lack the supervision and support to develop skills.³⁶

Staff undertook similar volumes of work in 2021 to 2020. However, the average caseload of each social worker remained higher than in 2015, with 16.3 cases per social worker in 2021 compared to 15 in 2015.³⁷ The 2021 British Association of Social Workers annual survey found increasing workloads were affecting staff wellbeing.³⁸

Figure 4.7 **Social worker turnover, 2013–2021**



Source: Institute for Government analysis of DfE, 'Social work workforce statistics' reporting year 2021, 'Caseloads, absence, vacancies, turnover and agency workers' table, supported by CIPFA. Notes: Following a methodology change comparable figures are not available before 2013; turnover is calculated by dividing the number of leavers during the year by the number of staff on 30 September.

Increasing workload pressures linked to Covid may have contributed to the increase in turnover rate seen in 2021/22, when almost 5,000 (FTE) social work staff left their job, equating to 15.4% of the total workforce.³⁹ A sustained turnover rate greater than 15% of the workforce since 2013/14 ultimately costs more for local authorities either directly through recruitment costs and higher wages to attract staff or indirectly through higher costs from private providers to fill staffing gaps.⁴⁰

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.⁴¹

Social work practices changed during the height of the pandemic but are returning to normal

Last year we reported that the pandemic had led to increased use of remote working tools while face-to-face contact was restricted. In general, regular face-to-face services resumed as restrictions were lifted, though some local authorities continued to use technologies such as WhatsApp to stay in contact with children.⁴² Some councils also prepared contingency plans on how to best prioritise work in response to the Omicron wave in December 2021.⁴³

Many local authorities need to improve the quality of children's social care

The lifting of Covid protection measures saw the return to regular Ofsted inspections from 12 April 2021 (for part of the year), which meant a snapshot of service performance can be provided as the UK exited the pandemic. The local authorities that Ofsted surveyed provided a similar level of service to before the pandemic, with 76 rated either outstanding or good (51%), 53 rated as requiring improvement (36%) and 19 rated as inadequate (13%).⁴⁴ Of these 148 authorities, 145 saw no change to their rating, two improved and one deteriorated (a further four authorities had yet to be assessed at the time of reporting).

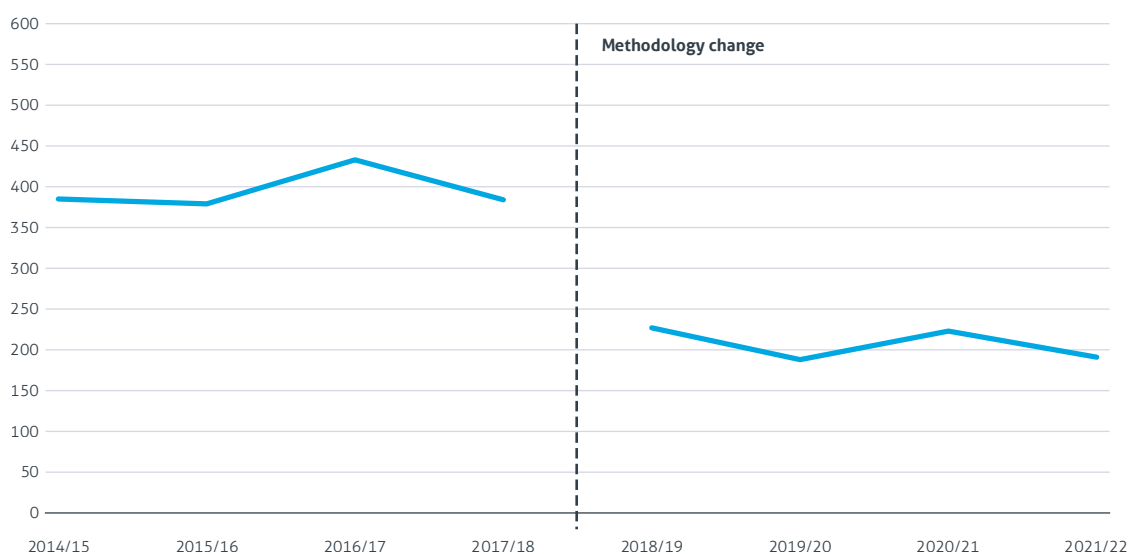
The Independent Review of Children's Social Care called for a radical change in services to make them more responsive, respectful and effective.⁴⁵ This includes changes to working practices and processes, as well as reform of the children's social care market.⁴⁶ Echoing similar calls from the children's commissioner,⁴⁷ it also called for children's voices to be better heard when decisions are made on their care packages.⁴⁸ Local authorities would need more funding to enact all these recommendations.

The number of registered serious incidents has reversed from its mid-pandemic high

Local authorities notify Ofsted when a child who was known to be at risk has later died or come to harm, using serious incident notifications. In 2021/22 there were fewer than 450 of these, compared to more than 500 in 2020/21.⁴⁹ However, it is too early to judge whether the decline in 2021/22 reflects a permanent reduction in comparison to the first year of the pandemic or whether the number will rise again in future years.⁵⁰

Following the tragic deaths of Arthur Labinjo-Hughes and Star Hobson a national inquiry recommended the need for dedicated multi-agency teams for every local area.^{51,52} If implemented, this might help to reduce the number of these incidents.

Figure 4.8 **Serious incident notifications, 2014/15–2021/22**



Source: Institute for Government analysis of DfE, 'Serious incident notifications' financial year 2021/22, 'All year totals' table, supported by CIPFA. Notes: Data is only available from 2014/15 onwards; the notification criteria for local authorities to report serious incidents changed in July 2018.

5. Neighbourhood services

Local authorities were increasingly stretched even before the pandemic began. The previous decade had seen successive central governments cut their grant funding, while demand for adult and children’s social care – among other statutory services such as homelessness services – continued to rise. These pressures forced councils to make tough decisions about which services they should prioritise and – more commonly – which they should scale back.¹ Neighbourhood services – food safety, health and safety, trading standards, libraries, planning, road maintenance, and waste collection and disposal – consequently entered the pandemic with radically reduced or changed amenities.

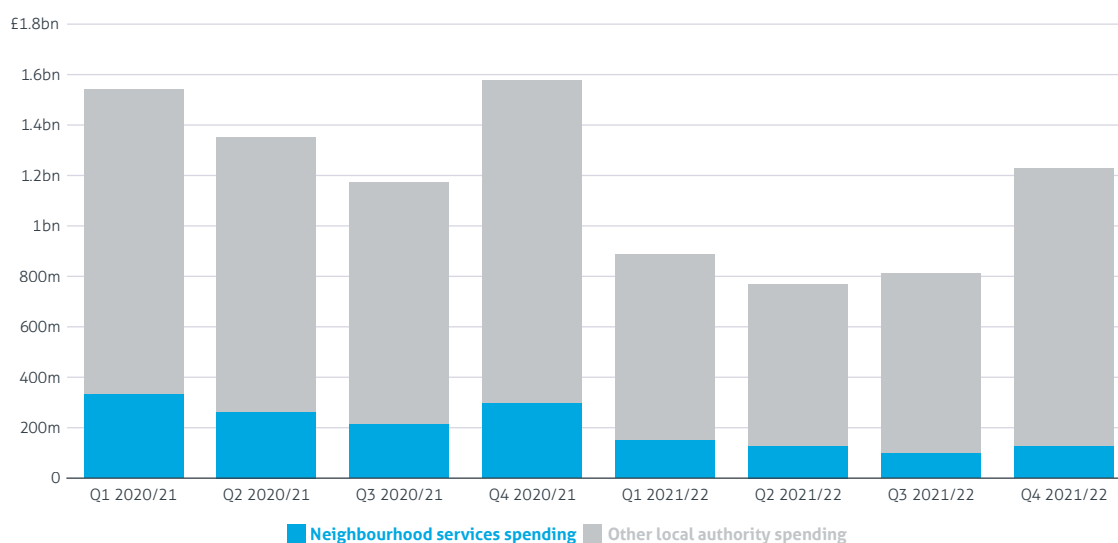
The effects of Covid restrictions on demand for neighbourhood services varied widely. Some – such as food safety, health and safety, and trading standards, which we refer to collectively as regulatory services – had to cease almost all activity due to social distancing rules and redeployment of staff to support authorities’ Covid response. Others – for example, libraries – continued to operate, though using novel or previously underutilised means. Others still, such as waste collection and planning, saw increased demand.

Looking ahead, neighbourhood services face several problems – and have some opportunities. There are backlogs in some services – such as planning and regulatory services – and others will now capitalise on Covid-era innovations to expand service provision. Local authorities leave the pandemic with their finances in an unexpectedly better state than many predicted,² with reserves increasing during the pandemic – though much of this increase is already earmarked for spending, meaning the increase is somewhat illusory and reserves are forecast to fall below pre-pandemic levels in 2021/22 and 2022/23.

The cost of living crisis will also threaten the financial sustainability of local authorities; councils are already reporting worsening recruitment and retention of staff as they struggle to compete with the wages offered by private sector employers.³ In addition, authorities that we spoke to are planning to extend service provision – for example, longer opening hours in libraries – to help communities struggling with the coming winter crisis.

Local authorities spent £4.9bn on emergency Covid support in 2021/22

Figure 5.1 Additional Covid spending on neighbourhood services and other local authority-provided services, Q1 2020/21 to Q4 2021/22



Source: Institute for Government analysis of DLUHC, 'Local authority Covid-19 financial impact monitoring information', rounds 1–20, Table 3: Expenditure due to COVID-19 by service line (£ millions). Other local authority spending excludes spending on public health, education services, police, fire and rescue services and foregone savings, supported by CIPFA. See Methodology for further details.

Local authorities spent £3.7bn on Covid support in 2021/22, down from £5.6bn in 2020/21.⁴ This money was spent on a range of local authority-supplied services, such as adult and children's social care, neighbourhood services, housing and central services.* In addition, local authorities lost income as receipts from business rates, council tax, sales, fees and charges fell. This lost income totalled £1.2bn in 2021/22, down from £5.1bn in 2020/21.⁵

Of the £9.3bn spent by local authorities on emergency support across the two years of the pandemic, £1.6bn was spent on neighbourhood services, with £1.1bn spent in 2020/21 and £512m in 2021/22.

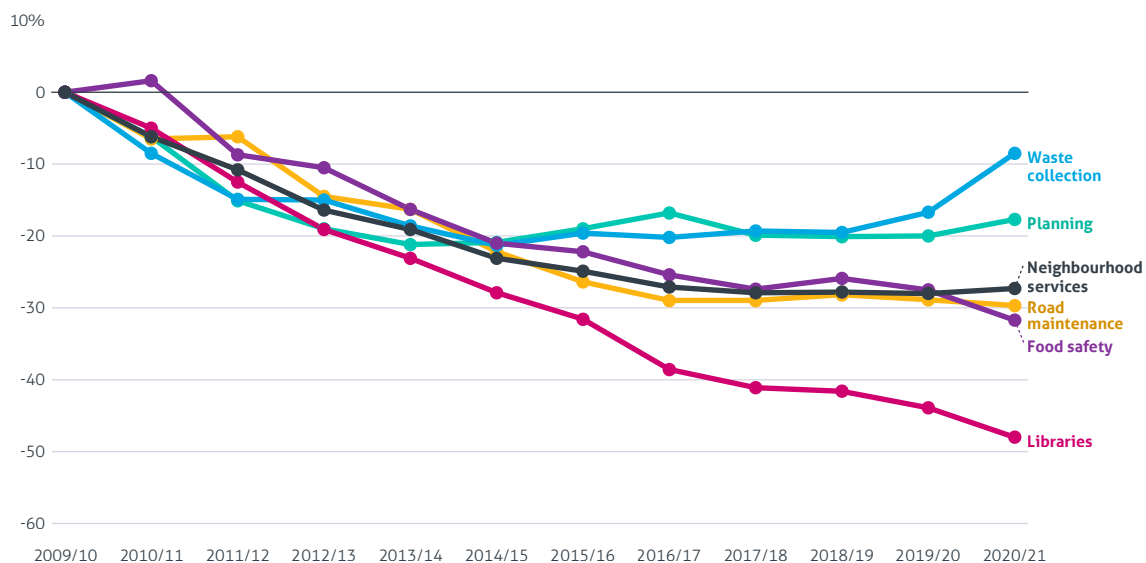
In response to the pandemic, central government provided local authorities with emergency funding that was intended to cover their increased costs and lost income.⁶ This support from central to local government totalled £15.2bn across 2020/21 and 2021/22,** with £9.4bn disbursed in 2020/21 and £5.8bn in 2021/22.⁷ Some of this funding was earmarked for specific purposes – for example, the Welcome Back Fund allocated £56m for reopening high streets in 2021/22⁸ – while central government provided £6.2bn of un-ringfenced funding across the two years, with £1.6bn falling in 2021/22.⁹

* This excludes spending on education services, public health and police, fire and rescue services to make these amounts comparable with other spending amounts in this chapter, where we also exclude these same items.

** It should be noted that the amount of funding that central government provided to local authorities does not match the amount that local authorities spent. This is because local authorities also have income from locally raised revenues – council tax, business rates and other income – as well as grants from central government that they would have received in the absence of the pandemic. Any additional money that was left over after emergency Covid spending would also have then been put into reserves, as discussed later in the chapter.

Spending on neighbourhood services rose, but with variation between services

Figure 5.2 Change in local authority spending on neighbourhood services in England since 2009/10 (real terms)



Source: Institute for Government analysis of DLUHC, 'Revenue outturn highways and transport services' and 'Revenue outturn cultural, environmental, regulatory and planning services', 2020/21, supported by CIPFA.

Overall spending on neighbourhood services increased by 1.1% in real terms between 2019/20 and 2020/21. This continues the trend of relatively flat spending changes since 2017/18. However, spending on neighbourhood services was 27.3% lower in real terms than 2009/10.

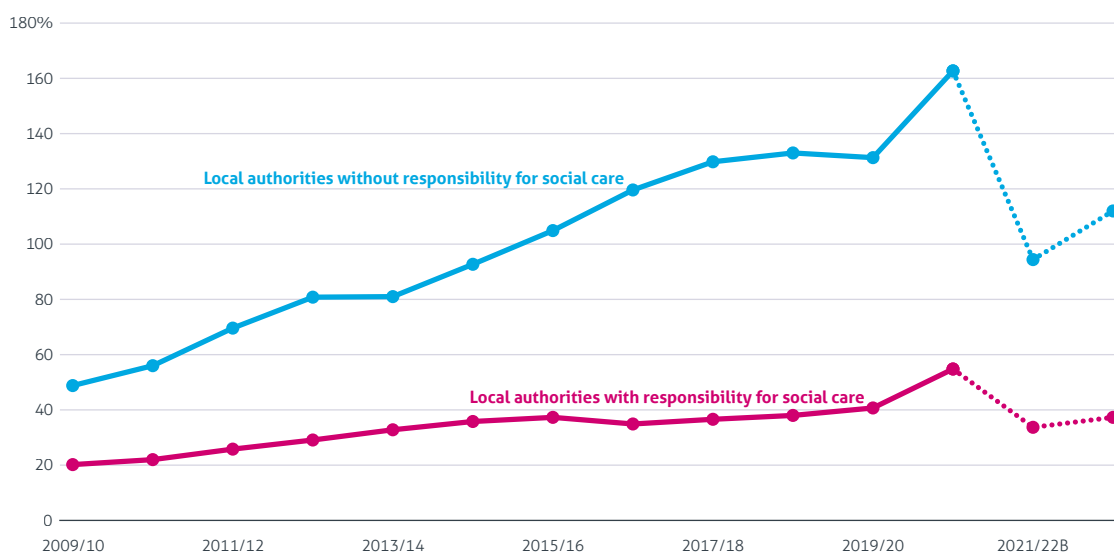
The relatively small spending increase in the last year hides variation between services. The service with the greatest annual decline was libraries, where funding fell by 7.3% in real terms between 2019/20 and 2020/21. Real-terms spending on libraries has now fallen 48% since 2009/10. In addition to libraries, spending on road maintenance, trading standards, food standards, and health and safety all fell. With the exception of road maintenance, these are all services that saw declines in activity during the pandemic as a result of social distancing requirements.¹⁰

Spending on both planning and waste collection increased in real terms between 2019/20 and 2020/21, by 3% and 9.8% respectively. Waste collection is the service that has seen spending cut least since 2009/10, at only 8.5% in real terms. Both services continued to operate relatively normally throughout the pandemic, with social distancing less of a concern. In both cases, activity in fact increased, driving spending increases, as discussed later in this chapter.

Local authority reserves increased in 2020/21

Despite expectations that reserves would fall during the pandemic,¹¹ usable reserves as a proportion of service expenditure increased in 2020/21, up to 163% for shire districts (which do not have responsibility for social care) and 55% for social care authorities, from 131% and 41% respectively in 2019/20. As this is the aggregate number, it hides variation between local authorities; of the 276 local authorities for which there is data, 84.8% increased their usable reserves in 2020/21, while 15.2% ran down their reserves.

Figure 5.3 **Usable reserves as a proportion of total expenditure by type of authority, 2009/10–2022/23**



Source: Institute for Government analysis of DLUHC, 'Revenue outturn summary', 2020/21 and 'Revenue account budget', 2021/22 and 2022/23, supported by CIPFA. Notes: dotted line represents budgeted change in local authority reserves as a proportion of total expenditure; see Methodology for further details.

Aggregate reserves increased for several reasons. First, central government determined how much support to provide to local government by surveying councils about the costs they expected to increase and the income they expected to lose. This process, however, didn't take account of areas – such as leisure centres – where Covid meant that spending declined,¹² thus overinflating expected costs.

Second, the uncertainty of the pandemic, particularly in the early months, meant that many local authorities submitted forecasts that ultimately turned out to overstate their cost pressures.¹³

Third, central government conducted survey rounds frequently, often as much as every month. Local authorities who were already struggling with resourcing sometimes submitted the previous estimate to save time.¹⁴ This is not to say that local authorities deliberately misled central government, but rather that the uncertainty and pressures of the pandemic resulted in overinflated estimates of the amount they would require.

Fourth, a large proportion – 19.6% – of 2020/21 emergency support was disbursed in March 2021, the end of the financial year. This made it difficult for local authorities to spend that money before the end of the financial year, therefore inflating reserves.¹⁵

It should be noted that this outcome is preferable to the opposite; local authorities were on the front line of the pandemic and it would have hurt England's response to Covid if insufficient funding had prevented them from responding effectively.

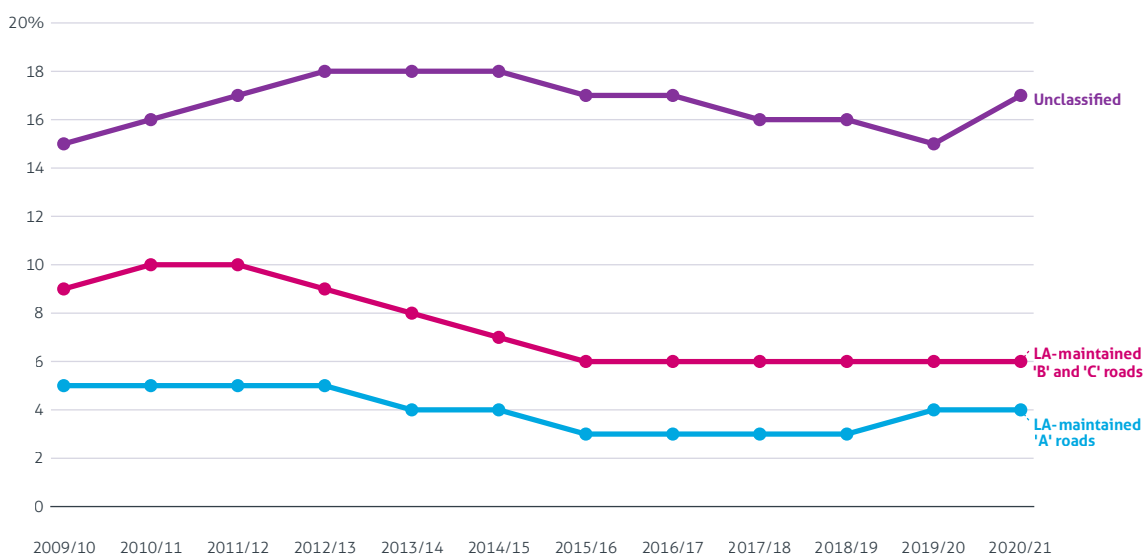
The high level of reserves at the end of 2020/21 does not mean that local authorities are in a more sustainable financial position than they were before the pandemic. This is for a number of reasons. First, 'usable reserves' is a combination of unallocated and earmarked financial reserves. Unallocated reserves can be spent at the discretion of the local authority, but local authorities set earmarked reserves aside for a specific purpose.¹⁶ Earmarked reserves as a proportion of usable reserves rose to 86.4% in 2020/21, up from 82.8% in 2019/20 and its highest level since at least 2009/10.

Second, and relatedly, local government often planned out the spending of grant funding over 2020/21 and 2021/22, despite receiving all funding from central government in 2020/21. Any money that was not spent at the end of the year was then put into reserves, inflating the number at year end.¹⁷ This is supported by forecasts that show usable reserves falling back to 33.7% and 94.4% for social care authorities and shire district authorities in 2021/22.¹⁸ That reserves are budgeted to fall in 2021/22 shows that local authorities planned to spend any saved emergency support funding and more in order to meet their obligations.

Neighbourhood service delivery has changed since the pandemic

The pandemic forced local authorities to deliver neighbourhood services differently. Social distancing requirements made it difficult for many services to operate as normal, with some moving their delivery online. In those services that ran a reduced service, local authorities redeployed many of the staff to Covid enforcement roles.¹⁹ Libraries responded to the pandemic by making many of their services virtual and also expanded the range of services they provided.²⁰ In addition to these more typical library duties, library staff also supported the community through programmes such as "Keep in touch" (KIT), in which library staff telephoned vulnerable people in the local community to help combat loneliness.²¹

Figure 5.4 Proportion of roads in need of maintenance by type, 2009/10–2020/21

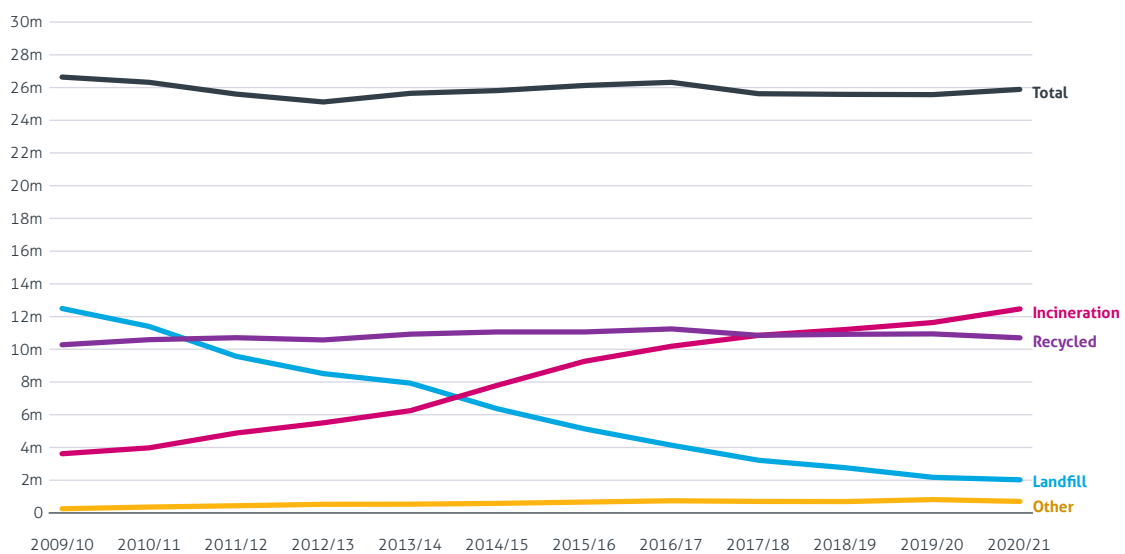


Source: Institute for Government analysis of DfT, 'Local authority managed classified/unclassified roads where maintenance should be considered', Table: RDC0120 and Table: RDC0130, 2020/21, supported by CIPFA.

With quieter roads and an outdoors working environment, some local authorities reported increasing road maintenance activity during the pandemic,²² though this did not result in an improvement in the proportion of local authority-maintained roads recorded as in need of maintenance. The proportion of classified roads (A, B and C) in need of maintenance remained stable between 2020/21 and 2019/20, while the proportion of unclassified roads in need of maintenance increased from 15% to 17%. This is likely to be because local authorities prioritised repairing roads in 'amber' condition²³ (according to the Road Condition Index, RCI²⁴), while the Department for Transport classifies a road as being in need of maintenance only if it is in 'red' condition. They prioritised these roads because the cost of repairing amber roads is lower than repairing red roads, which require more extensive work.²⁵

There was increased demand for waste collection during the pandemic. The kilograms of waste collected per person from homes increased from 392 in 2019/20 to 406 in 2020/21²⁶ – a 3.6% rise – as more people stayed at home.²⁷ How that waste was disposed of also changed. The proportion of household waste that was sent for recycling declined from 42.8% in 2019/20 to 41.4% in 2020/21 – the lowest level of recycling since 2011/12. The year 2020/21 was also the fourth in a row when incineration exceeded recycling as the most used method of waste disposal; 48.1% of waste being incinerated. This result also meant that the government missed its target to recycle 50% of household waste by 2020.²⁸

Figure 5.5 **Tonnes of waste disposed of by local authorities, by method, 2009/10–2020/21**



Source: Institute for Government analysis of Defra, 'ENV18: Local authority collected waste generation from April 2000 to March 2021 (England and regions) and local authority data April 2020 to March 2021', table 1a, supported by CIPFA.

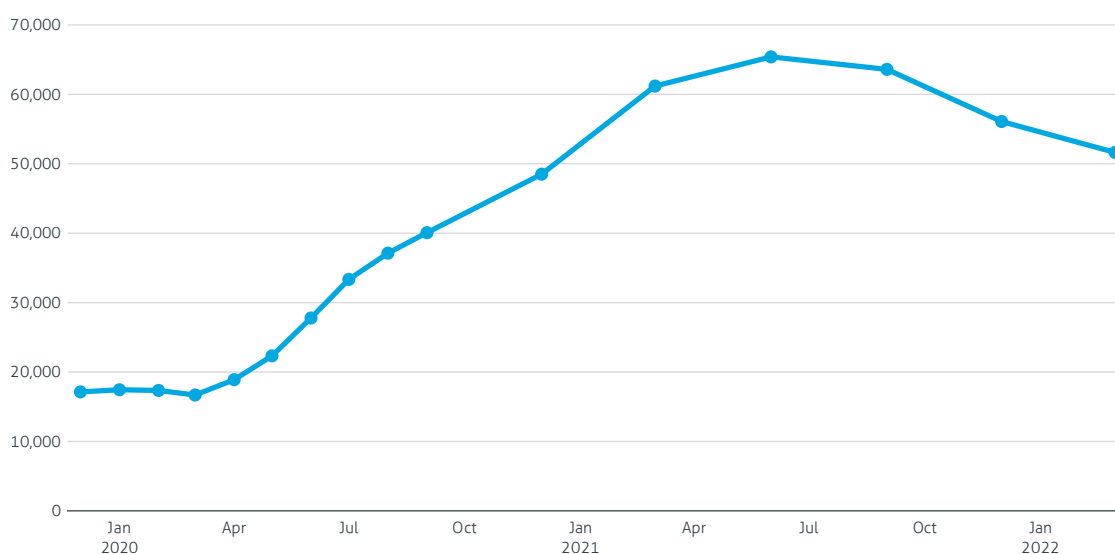
This reduction in the recycling rate occurred for a number of reasons. First, the amount of household waste increased during this time as more people stayed at home during lockdown, stretching recycling resources. It is notable that although the recycling rate declined year-on-year, local authorities recycled slightly more household waste in 2020/21 compared to 2019/20 – 10,077 compared to 10,057 thousand tonnes. Second, local authorities suspended some services during the pandemic. In particular, councils closed household waste and recycling centres (HWRCs) between April and

June 2020 – service points that normally make a large contribution to household waste recycling – and reopened them with some restrictions to maintain social distancing. Local authorities also chose to prioritise other services when the pandemic hit, and as a result paused the collection of low-priority garden waste from households.²⁹ One of the Department for Environment, Food and Rural Affairs’ hypotheses for why the proportion of recycling fell is that residents put (heavy) garden waste into residual bins following the suspension of garden waste services, increasing the tonnage of residual waste and consequently decreasing the proportion of recycled waste.³⁰

Lockdown caused backlogs in some neighbourhood services

Social distancing requirements, a reduced workload as pubs and restaurants closed, and the need to enforce Covid regulations³¹ meant that local authorities stopped normal patterns of compliance work in areas such as food safety, health and safety, and trading standards.

Figure 5.6 **Businesses awaiting a food inspection, December 2019 to March 2022**



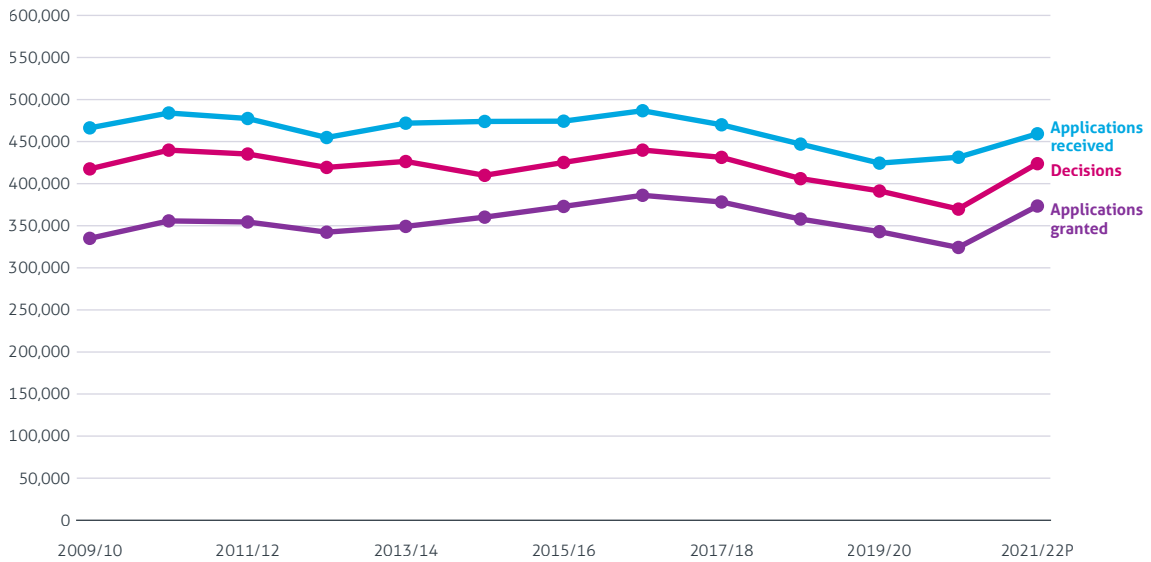
Source: Institute for Government analysis of FSA, Performance and Resources reports, supported by CIPFA.
Notes: Data moved from being reported monthly to quarterly after September 2020.

This reduction in activity created a backlog of food safety inspection, though local authorities are already making progress in reducing this. The Food Standards Authority (FSA) reports that the number of food businesses awaiting inspection in England at the end of March 2022 was 51,633³² down from a high of 65,400 at the end of June 2021³³ – a 21.1% reduction in nine months – though this is still 201.2% higher than the 17,343 businesses awaiting inspection in February 2020³⁴. Local authorities are making this progress by following the FSA’s Covid recovery plan, which recommends prioritising high-risk and non-compliant establishments while implementing an ‘intelligence-based’ approach for low-risk establishments – in other words, not conducting unnecessary inspections of compliant establishments.³⁵

A return to normal staffing patterns after Covid has also helped this. In March 2021, only 43.4% of food hygiene and food standards staff were available to carry out food controls. This increased to 82.4% by October 2021 and 88.7% by March 2022.³⁶

Trading standards has not accumulated a backlog in activity in the same way that food work has, as it does not involve the same levels of programmed inspections, but it is still under pressure. The Chartered Trading Standards Institute has warned of a possible boom in fraud as criminals take advantage of consumers struggling with the cost of living crisis and an understaffed trading standards workforce.³⁷

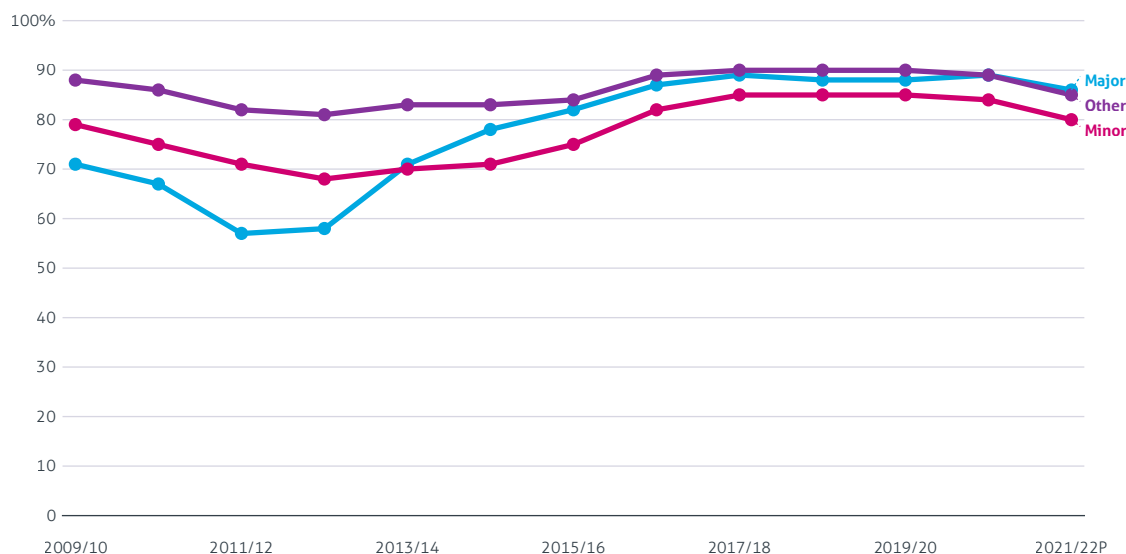
Figure 5.7 **Planning applications received by local authorities, decisions made and applications granted, 2009/10–2021/22**



Source: Institute for Government analysis of DLUHC, Table P120: 'District planning authorities – planning applications received, decided, granted, performance agreements and speed of decisions, England' 2021/22, supported by CIPFA. Notes: The P in 2021/22P stands for provisional.

Planning departments are also struggling with their own backlog. The number of planning applications received increased for the second year in a row in 2021/22, up to 459,331 from 431,396 in 2020/21 – a 6.5% year-on-year increase and the highest number of applications since 2017/18. There were a number of reasons for this increase. First, people spent more time at home during lockdown and wanted to improve their properties.³⁸ Second, in the absence of other usual spending on things such as going out, travel or holidays, households had more disposable income, which they chose to spend on home improvement.³⁹

Figure 5.8 **Planning applications decided within agreed time limit, by type, 2009/10–2021/22**



Source: Institute for Government analysis of DLUHC, 'Table P120: district planning authorities – planning applications received, decided, granted, performance agreements and speed of decisions, England', 2021/22, supported by CIPFA. Notes: Major decisions have a standard target of 13 weeks and minor decisions have a target of eight weeks.

Rising applications requires an increase in the number of responses. The number of decisions increased faster than applications between 2020/21 and 2021/22, rising 14.6% from 369,751 to 423,765. The speed of responding to applications, however, fell in 2021/22 across all three types of planning applications. The proportion of major, minor and other applications that local authorities decided within the agreed time limit fell by 3, 4 and 4 percentage points respectively. This decline is driven by a few factors. First, there is a lack of resource within local authorities⁴⁰ that predates the pandemic.⁴¹ Cuts to local authority budgets since 2010 have resulted in fewer planning officers, who are now struggling to deal with the Covid-induced backlog. Second, retention of planning officers has worsened over the pandemic as they have faced high workloads and the difficulties of remote working, further slowing response times.⁴² Third, local authorities have increasingly prioritised major planning applications – for which they are able to charge a larger fee – as they have been forced to supplement cut budgets with locally raised revenue.⁴³

Local authorities are struggling with recruitment and retention

As with many other public services, local authorities are finding it difficult to meet staffing requirements in a tight labour market.

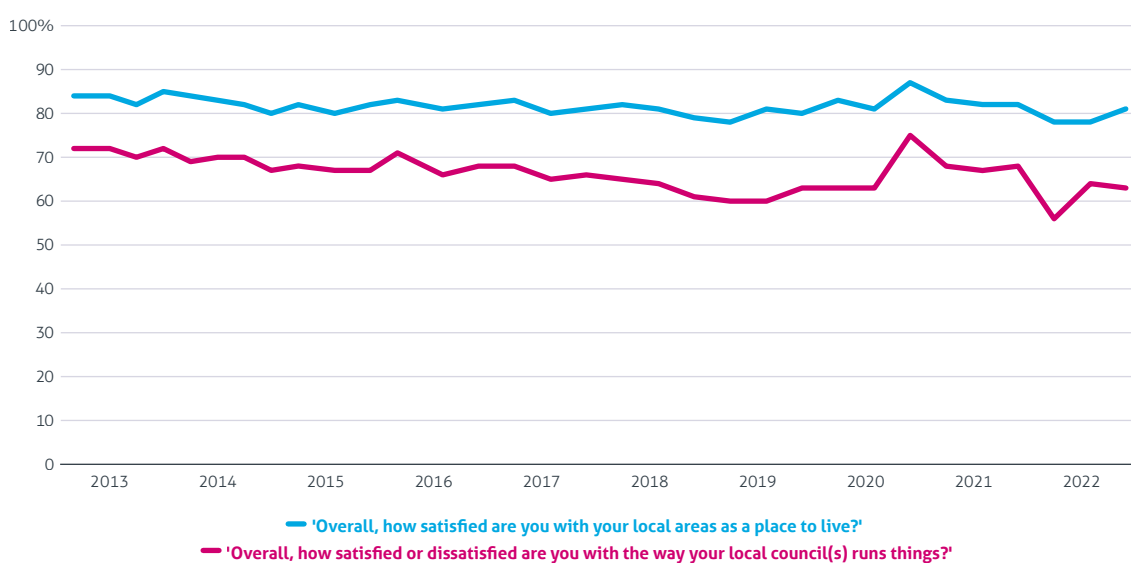
Local authorities are struggling to compete with private sector pay and are losing staff because of it.⁴⁴ One interviewee from a local authority told us that an employee in their IT department left the organisation for a private sector role where they were paid more than double their local authority salary, with the benefit of working completely remotely.⁴⁵ The same interviewee told us that their local authority was struggling to recruit lawyers, accountants and other professionals who all found more competitive pay in the private sector.⁴⁶ In January, 60% of councils responding to a survey reported either a large or moderate concern that they would not be able to deliver the same quality of services over the next six months due to workforce issues.⁴⁷

Covid is also still contributing to this workforce crisis. In a survey conducted by the Local Government Association (LGA) in January 2022, 63% of councils that responded reported that they had staff absences due to long Covid.⁴⁸

Local authorities are using workforce practices from the pandemic to help alleviate some of these pressures. At the height of the pandemic, local authorities deployed staff from areas with workforce capacity to others that needed support.^{49,50} One interviewee told us that their council developed a platform for recording workforce capacity and facilitating the movement of staff from one area of the council to another during the pandemic, which they continue to use to ease some of the worst of the workforce crisis.⁵¹

Satisfaction with councils remains above pre-pandemic levels

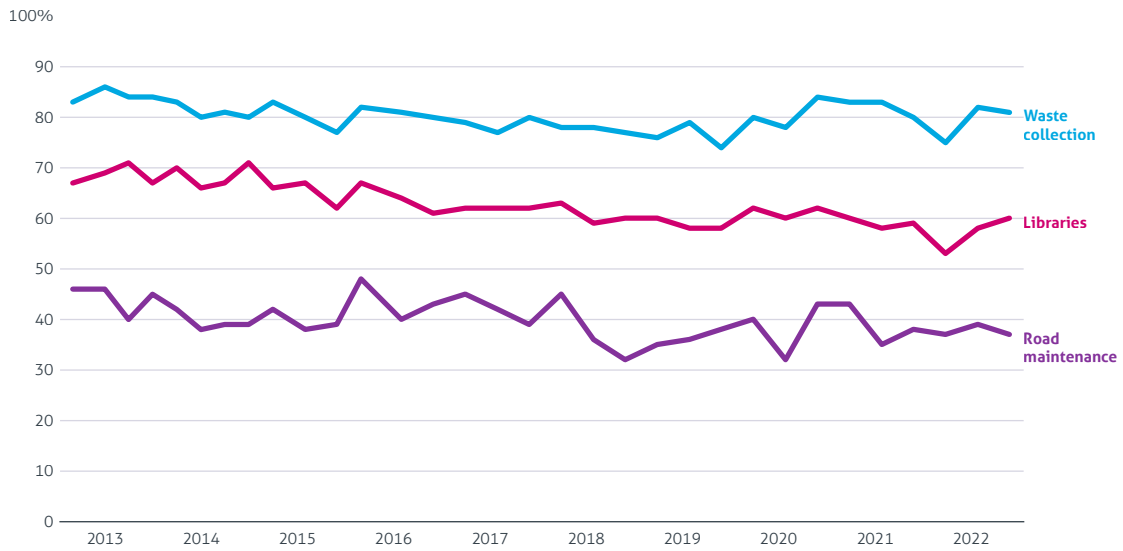
Figure 5.9 **Public satisfaction with local area and local council, September 2012 to June 2022**



Source: Institute for Government analysis of Local Government Association, 'Polling on resident satisfaction with councils: Round 32 – June 2022', Figure 1: Overall, how satisfied are you with your local areas as a place to live? & Figure 2: Overall, how satisfied or dissatisfied are you with the way your local council(s) runs things?, supported by CIPFA. Notes: Time series does not start in 2009/10 because polling was not carried out until 2012.

After a slight dip in the third quarter of 2021, 63% of residents were either very or fairly satisfied with their local council in June 2022, on a par with three years earlier.⁵² Similarly, public satisfaction with their local area was at 81% in June 2022, compared to 80% in June 2019.⁵³

Figure 5.10 **Public satisfaction with neighbourhood services, September 2012 to June 2022**



Source: Institute for Government analysis of Local Government Association, 'Polling on resident satisfaction with councils: Round 32 – June 2022', Figure 11: Levels of satisfaction with key council services – June 22, supported by CIPFA. Notes: Time series does not start in 2009/10 because polling was not carried out until 2012.

Roughly the same trend occurred for road maintenance. In June 2019, 38% of residents were either very or fairly satisfied with the service. This then fell only slightly to 37% in June 2022. In the other two services for which there is data – waste collection and libraries – satisfaction increased, from 74% to 81% and from 58% to 60% in that same period.⁵⁴

6. Schools

The closure of schools was one of the starkest examples of public service disruption wrought by Covid, with in-person teaching not offered for most pupils for more than a quarter of the 2019–20 and 2020–21 academic years combined.^{*1} Schools are now attempting to make up for the learning lost during this time.

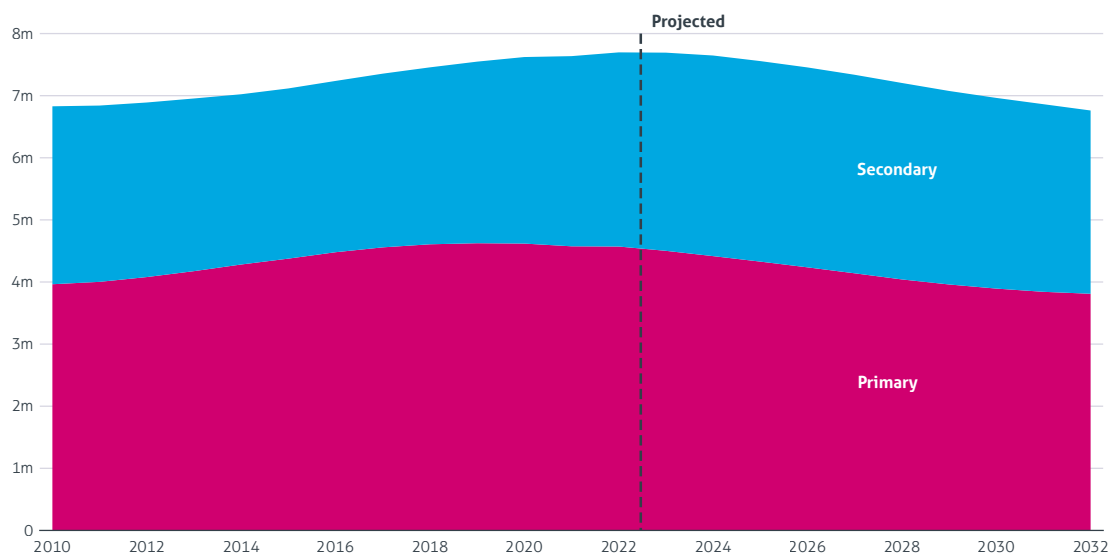
But while schools are receiving more funding than at any point in the preceding decade, staffing costs have increased, insufficient numbers of teachers are being trained in many subjects and schools are having to do more to support pupils with special educational needs and disabilities.

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 (schooling for those who cannot receive their education in mainstream schools, for example because of exclusion), early-years and post-16 education.

Demands on schools have increased

Pupil numbers have been increasing overall in recent years, with a small decline in the number of primary school pupils being more than offset by an increase in secondary school pupil numbers. The government forecasts that pupil numbers peaked in 2022 and will decline for the next decade.²

Figure 6.1 Pupils in state-funded schools, actual and projected, 2010–2032



Source: Institute for Government analysis of Department for Education (DfE), 'National pupil projections: July 2022', supported by CIPFA. Notes: Figures are as at January of the given year.

* 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.

Other demands on schools have also increased. There has been a huge rise in the number of children who require a higher level of special educational needs and disabilities (SEND) support. Since 2016, the number of pupils with an education, health and care plan, which sets out specific support a child requires, has increased from 237,000 to 356,000. Around half of these pupils are in state-funded mainstream primary and secondary schools.³

Many schools are also finding that they are having to do more than in 2010/11 to make up for reduced local authority services and stretched children and young people's mental health services.⁴ Research suggests most local authorities that previously offered educational psychologists to schools for free now charge for the service.⁵ And in a pre-pandemic survey by the National Foundation for Educational Research, more than half of secondary school leaders said that their school had contracted external specialists to deliver mental health and wellbeing services.⁶

Overall per-pupil funding has increased but funding reforms led to real-terms cuts for some schools in deprived areas

In both the 2019 spending round and the 2021 spending review, the government allocated more money to the core schools budget.^{7,8} This has been enough to counterbalance increasing pupil numbers: per-pupil funding for the 2021/22 financial year reached its highest level since 2010/11 in real terms, with schools receiving an average of £6,510 per pupil.⁹ Stated in 2021/22 prices, this was intended to increase again to £6,698 per pupil in 2022/23 – high inflation since the Department for Education (DfE) produced this forecast at the start of 2022 will have eroded some of this gain, however.*

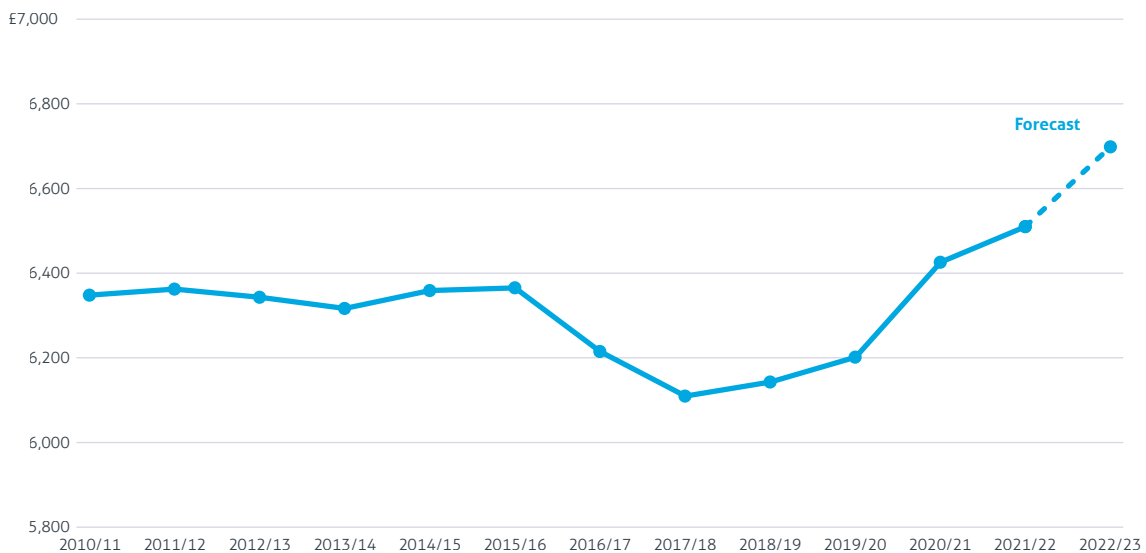
It should be noted that, including school sixth-forms (outside of the scope of this chapter, but where there have been greater funding cuts than in 5–16 education) and accounting only for general, economy-wide inflation, the Institute for Fiscal Studies forecasts that school spending per pupil will return to 2009/10 levels only in 2024/25.¹⁰

While per-pupil funding has increased on average, the experience of individual schools varies. The government introduced a national funding formula in 2018/19 to address discrepancies in funding that schools in different parts of the country received.**¹¹

* These figures cover both mainstream and non-mainstream schools, and exclude specific Covid funding.

** The national funding formula currently operates in a form in which funding allocations set by DfE can be revised at local authority level. Implementation of a 'direct' national funding formula, without substantial local adjustment, may not be complete until 2027/28. See DfE, *Implementing the Direct National Funding Formula: Government consultation*, p. 7, 7 June 2022, https://consult.education.gov.uk/funding-policy-unit/implementing-the-direct-national-funding-formula/supporting_documents/Implementing%20the%20direct%20national%20funding%20formula%20%20government%20consultation.pdf.

Figure 6.2 **Per-pupil funding for state-funded schools, 2010/11–2022/23 (2021/22 prices)**



Source: Institute for Government analysis of DfE, 'School funding statistics: Financial year 2021–22', supported by CIPFA. Notes: Comparable figures are only available from 2010/11; figures cover major revenue funding streams, but exclude some smaller elements of revenue funding and specific Covid-19 funding; figures cover both mainstream and non-mainstream schools. See Methodology for details of how figures have been put into 2021/22 terms.

Schools serving more deprived communities still get more funding than those in less deprived ones. But analysis by the National Audit Office found that between 2017/18 and 2020/21 most London boroughs saw real-terms decreases in per-pupil funding, as did cities with relatively high levels of deprivation such 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. The main reasons for this were that the national funding formula newly took into account changes in the relative deprivation of places such as London and included minimum per-pupil funding that benefited some parts of the country more than others.¹²

Higher schools spending reflects increased costs

In 2020/21, £51.5 billion was spent on the schools system, including non-mainstream schools – up from £47.1bn the previous year.¹³ This was the first full year of the pandemic, though only £1.4bn of the 4.4£bn increase in spending was specifically due to Covid. Around £1.5bn came as part of an increase in general funding for schools, with an increase of almost the same amount split between two other factors.

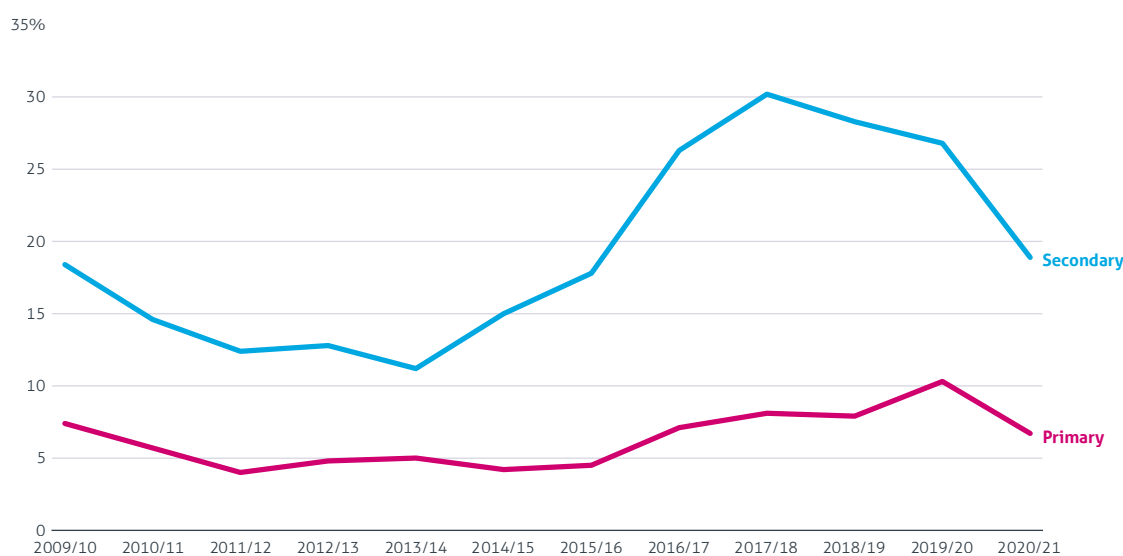
First, a grant to help schools cope with higher teacher pension costs. Staffing costs account for around 80% of school spending, and have been subject to several exceptional increases since 2010.¹⁴ The employers' contribution rate for teacher pensions increased from 14.1% to 16.4% in April 2015, then to 23.6% in September 2019.^{15,16} The Treasury also expects funding for 2022/23 to cover teacher pay increases from September 2022 that the Institute for Fiscal Studies has calculated will average 5.4%, discussed further below.¹⁷

Second, extra spending on high needs – support for SEND pupils, as well as spending on alternative provision. As noted above, there has been a big increase in the number of children with education, health and care plans. As a result high needs spending is increasing faster than spending on schools in general and totalled £6.6bn in 2020/21.^{18,19,20} In early 2022 the government published a SEND green paper that aims to standardise SEND provision nationally and improve early intervention. If implemented, the proposals may have the effect of controlling SEND costs to some extent – but the government is likely to face opposition from parents given they would also reduce their freedom in picking a school for their child.^{21,22}

The financial position of schools improved in the first year of the pandemic

Despite the additional demands noted above, in 2020/21 the percentage of local authority-maintained schools with cumulative negative reserves – a proxy for financial distress* – was lower than at any point since 2015/16.^{23,24,25,26,27,28} The DfE puts the improvement in school reserves between 2019/20 and 2020/21 down to the pandemic, with schools spending less on supply teachers, learning resources and exam fees among other areas.²⁹

Figure 6.3 Local authority-maintained schools with negative financial reserves, 2009/10–2020/21



Source: Institute for Government analysis of DfE, 'LA and school expenditure', 'LA maintained schools, revenue reserves' table, 2010–2021, supported by CIPFA. Notes: Figures relate to revenue (day-to-day) spending.

The share of academy trusts with cumulative negative reserves, including those covering non-mainstream schools, also decreased between 2018–19 and 2020–21, from 6.0% to 2.6%.^{**30,31}

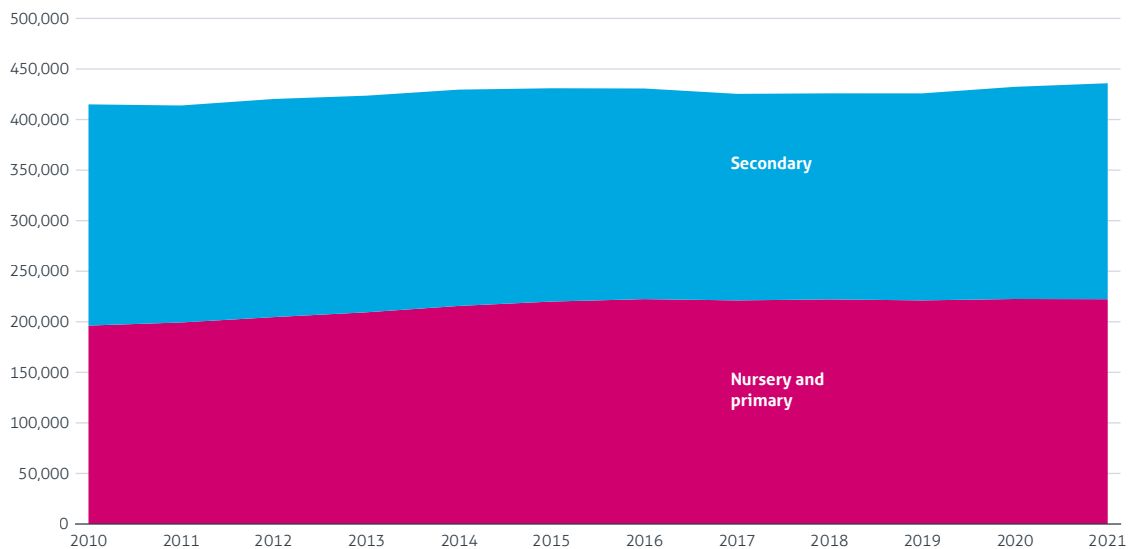
* Reserves show the cumulative financial position of schools. If schools record in-year deficits this can ultimately lead to them building up negative reserves – in this situation, local authority-maintained schools are reliant on their local authority supplying additional funding. Academy trusts are reliant on support from the Education and Skills Funding Agency.

** Academy trusts' financial years are aligned to the academic year, unlike those of local authority-maintained schools.

Overall teacher numbers increased in the first year of the pandemic...

Overall teacher numbers have been increasing since 2018. Nursery and primary teacher numbers have been broadly stable, but secondary full-time equivalent employee numbers have increased by 4.8% over that period.³²

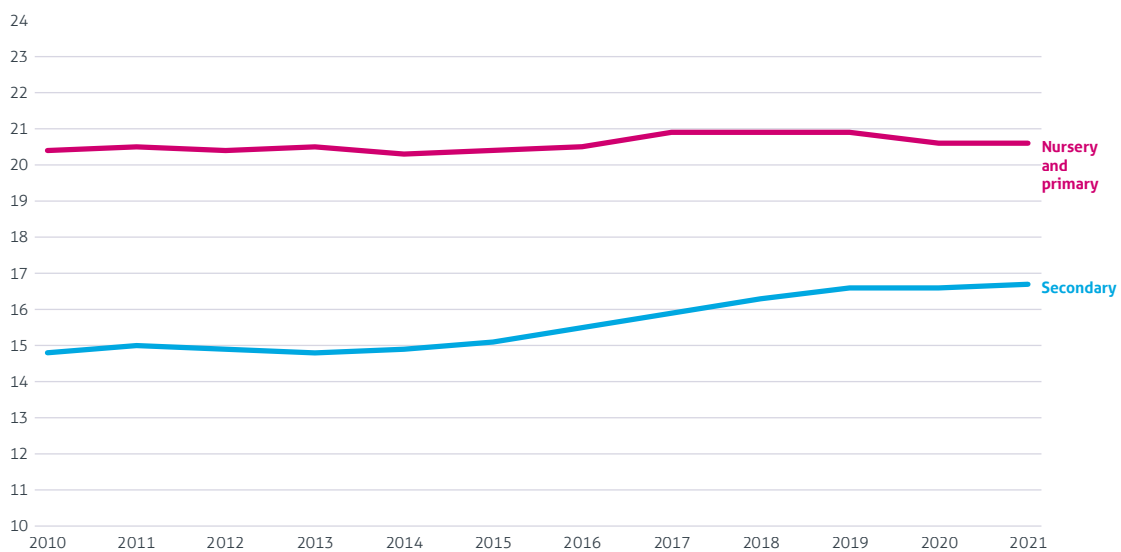
Figure 6.4 Teachers in state-funded schools, full-time equivalent, 2010–2021



Source: Institute for Government analysis of DfE, 'School workforce in England: Reporting year 2021', 'Teacher and support staff full-time equivalent and headcount numbers' table, supported by CIPFA. Notes: Figures are as of November in the relevant year and include both qualified and unqualified teachers.

With the number of younger children decreasing, nursery and primary pupil–teacher ratios have fallen since 2019, while the increase in secondary teacher numbers has been enough to keep secondary pupil–teacher ratios broadly stable, despite a growing number of secondary school pupils.³³

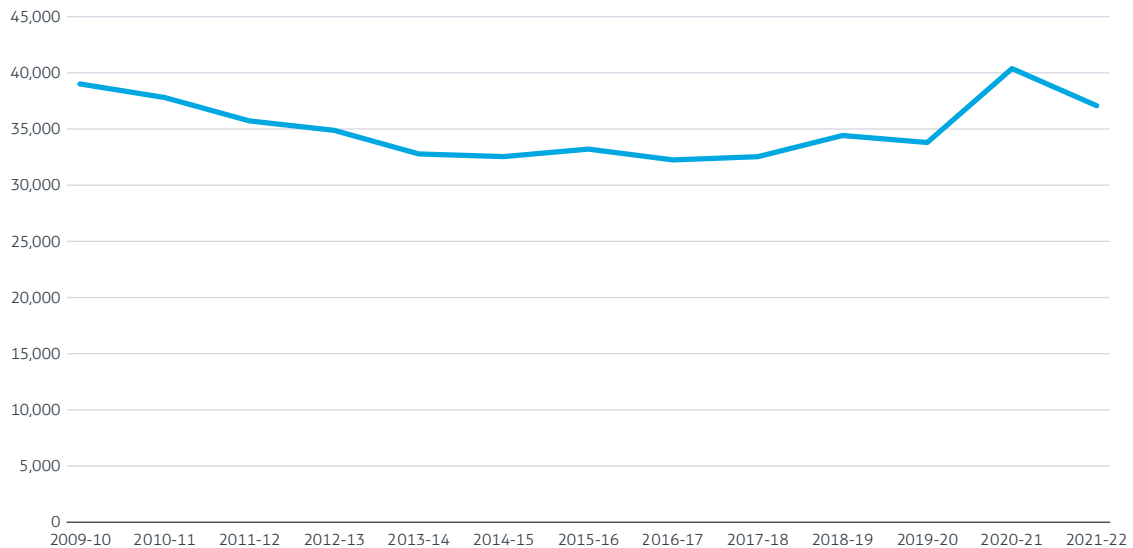
Figure 6.5 Average pupil–teacher ratio in state-funded schools, 2010–2021



Source: Institute for Government analysis of DfE, 'School workforce in England: Reporting year 2021', '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; figures include both qualified and unqualified teachers.

As has been observed at other times of crisis, teacher recruitment was boosted by the pandemic with more than 40,000 new entrants to initial teacher training in 2020–21 – the highest level since at least 2009–10.³⁴ And in secondary, where historically there are greater recruitment problems than in primary, the government hit its overall target for postgraduate teacher training that year – the first time this has happened since 2012–13. Trainee numbers dropped back somewhat in 2021–22, however.

Figure 6.6 **Entrants to initial teacher training, 2009–10 to 2021–22**



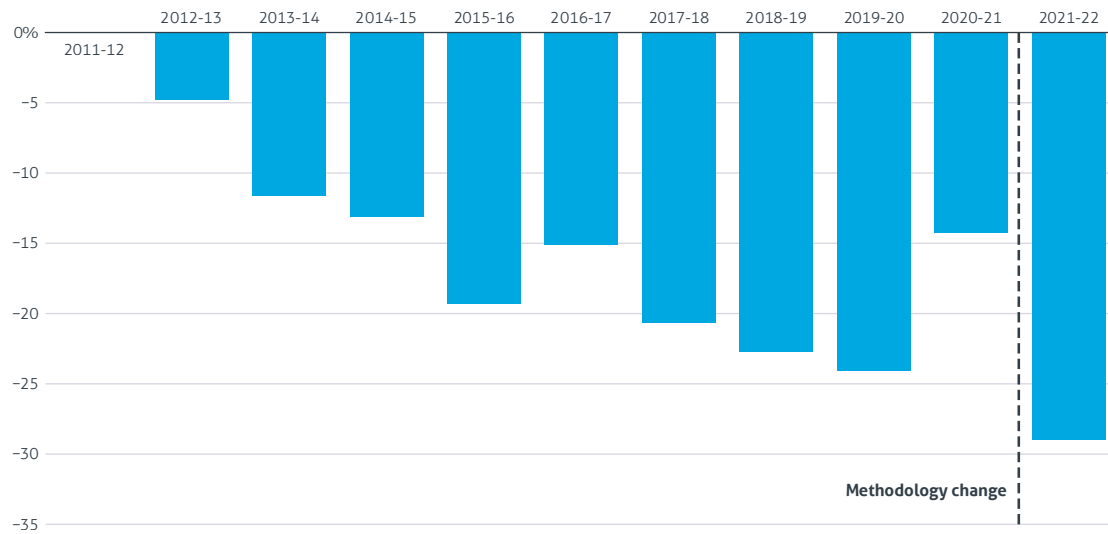
Source: Institute for Government analysis of DfE, 'Initial Teacher Training Census: Academic Year 2021/22', 'ITT new entrants by subject and training route' table, supported by CIPFA.

But staff increases mask shortfalls in many subjects

However, behind the overall numbers, the picture is less encouraging. The government is not succeeding in training enough teachers in all of the subjects in which they are needed. The government sets annual, subject-by-subject initial teacher training recruitment targets, covering postgraduate training – in several subjects, including physics, design and technology, and languages, shortages are both severe and persistent.

What we therefore refer to as the underlying shortfall in initial teacher training for secondary teachers – the cumulative shortfall across individual subjects, ignoring over-recruitment in other subjects – fell in 2020–21. But it rose again in 2021–22, hitting 29% – that is, a shortfall of nearly a third, versus targets. A change in how the DfE calculates subject targets may have contributed to this. The new methodology is, however, intended to give a more accurate picture of whether enough teachers are being trained to meet demand.³⁵

Figure 6.7 **Underlying shortfall in postgraduate initial teacher training recruitment for secondary school teachers, 2011–12 to 2021–22**



Source: Institute for Government analysis of DfE, initial teacher training census, 'ITT new entrants and targets by subject time series' table, 2015/16–2021/22, supported by CIPFA. Notes: Underlying shortfall is calculated as the cumulative shortfall across individual subjects, ignoring over-recruitment in other subjects; comparable figures are not available for 2009–10 and 2010–11; there was no shortfall in 2011–12. Since 2021–22 DfE has taken under-recruitment in the preceding two years into account in setting subject targets.

Retention rates improved before the pandemic but this is unlikely to persist

Retention rates for teachers in the first two years of their career increased slightly immediately before the pandemic – for those who qualified in 2016, 77.6% were still in teaching in 2018; for those who qualified a year later, 78.3% were in teaching in 2019.³⁶ This increased further during the pandemic – the two-year retention rate was 82.7% for those qualifying in 2019, the latest cohort for which data is available.

Pay is one factor that affects recruitment and retention, and the government also increased teacher salaries in September 2022 following a one-year pay freeze. This included an increase of 8.9% for the lowest paid qualified teachers as part of plans to reach 30,000£ starting salaries for all qualified teachers in 2023–24* – one year later than initially planned.^{37,38,39} But while higher pay for the lowest paid may have some effect on retention, it seems unlikely that the boost to retention rates during the pandemic will persist.

Overall, teacher pay was expected to increase by an average of 5.4% from September 2022, the Institute for Fiscal Studies has calculated, an increase which schools are required to cover from the funding allocated to them in the 2021 spending review.⁴⁰

* Pay levels for teachers in London already start above £30,000.

Pupils have missed large amounts of education, with primary results falling

For two academic years, 2019–20 and 2020–21, in-person teaching was interrupted by national lockdowns, with high levels of pupil absence at other times.⁴¹ Attendance was much better in 2021–22, with a median figure of 89.7%. (In 2018/19, the last complete pre-pandemic year, attendance was 95.3%, though based on a different methodology.)^{42,43} Figures for the first term of 2021–22, however, show that nearly 98,000 pupils missed 50% or more of school sessions, which will have brought the median figure down.⁴⁴

Multiple studies have found that as a result of this disruption pupils lost learning during 2019–20 and 2020–21, with disadvantaged pupils particularly badly affected.⁴⁵ Available evidence, which has tended to focus on primary school pupils, generally shows that there had been some recovery by summer 2021, but that on average pupils were still behind where previous cohorts had been.

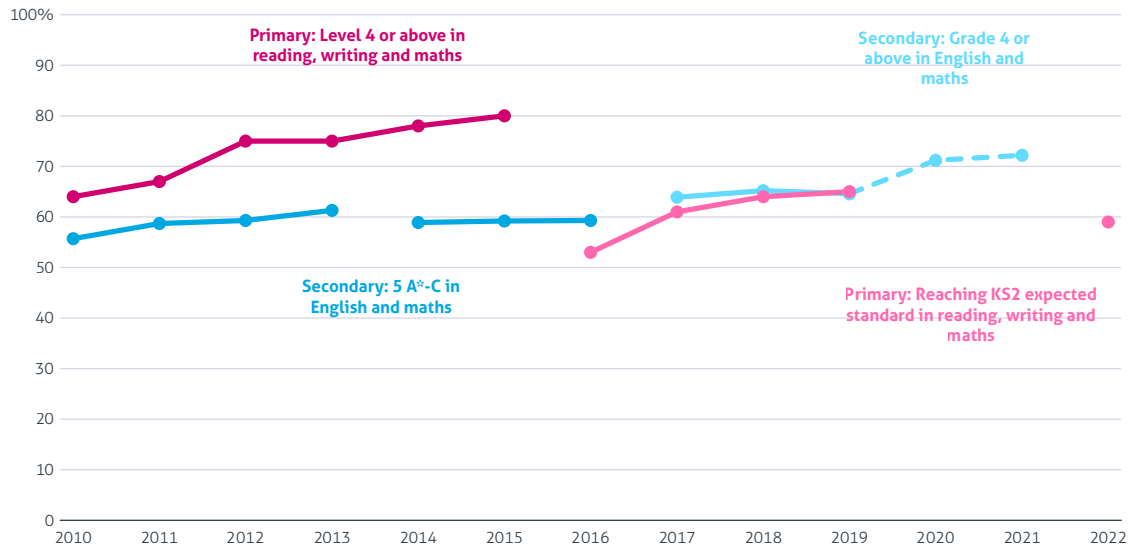
The government cancelled Key Stage 2 assessments, covering pupils at the end of primary school, in 2020 and 2021. Pupils were assessed in 2022, however, with interim results showing a fall in the percentage of pupils meeting the expected standard in reading, writing and maths from 65% in 2019 to 59% in 2022.⁴⁶ Under the two forms of Key Stage 2 assessment that have been in place since 2010, this is the first time that attainment has fallen.

This was driven by steep falls in maths and writing attainment, while attainment in reading increased slightly, from 73% of pupils reaching the expected standard to 74%. There is a lack of solid evidence on the reasons for this variation.

GCSEs and other external assessments were also cancelled for secondary pupils in 2020 and 2021 – with a major backlash in 2020 against plans to use an algorithm to set grades. Grades were set instead by schools and regulators in 2020, and schools in 2021, and were considerably higher than those in previous years.⁴⁷ GCSE exams took place in 2022, with results artificially set between pre-pandemic 2019 levels and 2021 levels.⁴⁸ Alternative evidence – the National Reference Test, taken by a sample of pupils at the end of secondary school – found a statistically significant fall in maths attainment from shortly before the pandemic hit in 2020 to 2022, but no statistically significant fall in English language.⁴⁹

* Figures for 2021–22 relate to all state-funded schools, including state alternative provision, whereas figures for 2018–19 do not include alternative provision. Figures for 2021–22 also include pupils in Reception and pupils in sixth forms, whereas those for 2018–19 include only pupils aged 5–15. Finally, figures for 2018–19 are derived from the overall absence rate and count someone doing approved off-site educational activity such as job interviews as attending, while figures for 2021–22 only count in-person school attendance.

Figure 6.8 Attainment at the end of primary and secondary school in state-funded schools, 2010–2022

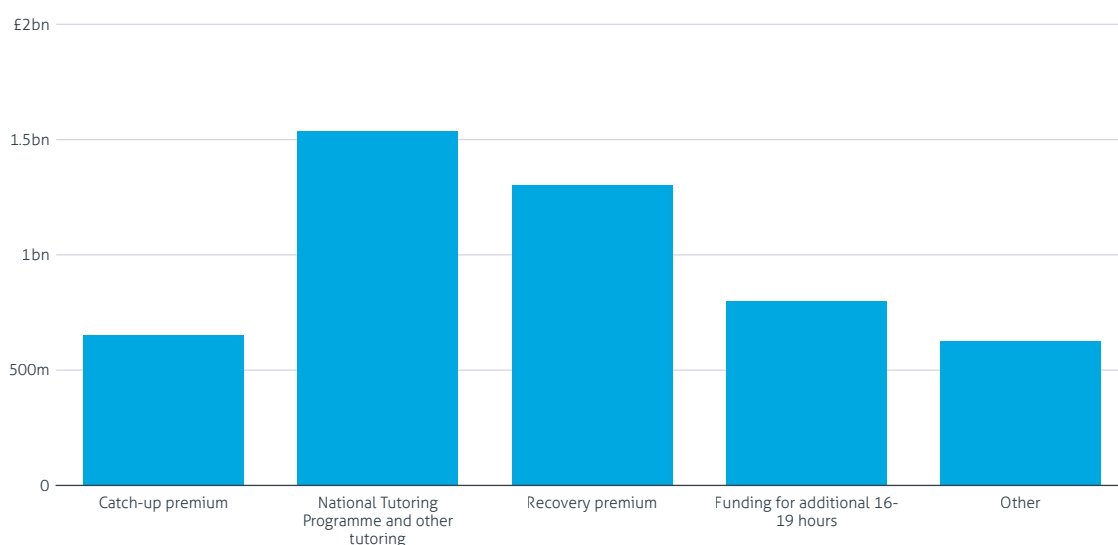


Source: Institute for Government analysis of DfE, Key Stage 2 statistics, 2010–2022; DfE, GCSE and equivalent results, national tables, 2010–2021; supported by CIPFA. Notes: Primary school assessments were reformed between 2015 and 2016; between 2013 and 2014 a number of changes were made to secondary qualifications; reformed English and maths GCSEs were awarded for the first time in 2017; in 2020 and 2021, KS2 tests did not take place and GCSE results were awarded on the basis of centre-/teacher-assessment rather than external assessment; grade 4+ results in English and maths have yet to be published for 2022; results include those not in mainstream education.

The National Tutoring Programme has had problems but catch-up schemes are now reaching large numbers of pupils

Since June 2020 the government has committed £4.9bn for educational catch-up, allocated between the 2020–21 and 2023–24 school years.⁵⁰ This is significantly less than the roughly £15bn recommended in 2021 by the government’s education recovery commissioner,⁵¹ and as such is likely to be insufficient to allow schools to fully make up for lost learning.

Figure 6.9 Education catch-up funding for academic years 2020–21 to 2023–24



Source: Institute for Government analysis of Education Select Committee, 'Is the catch-up programme fit for purpose?', table 1, supported by CIPFA. Notes: Tutoring interventions consists of the 16–19 tuition fund as well as the National Tutoring Programme; catch-up premium and recovery premium are two types of funding supplied to schools with limited conditions attached; 'other' includes early years support; some Covid-19 support isn't included, e.g. funding for digital devices.

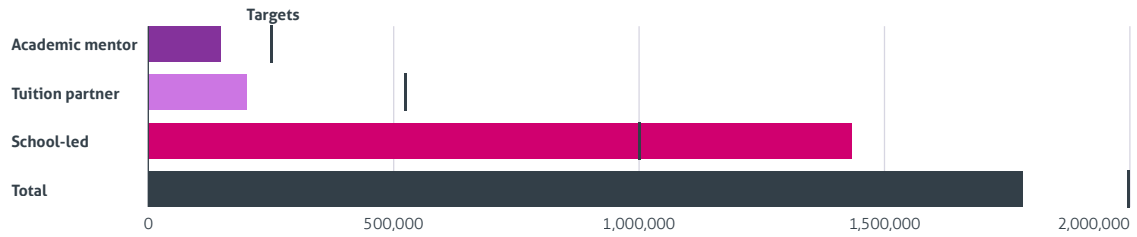
The largest single component of this funding, at £1.5bn, is tutoring interventions: the government’s National Tutoring Programme, launched in November 2020, together with a smaller programme of 16–19 tuition.⁵²

In its first years of operation, schools complained about the bureaucracy of the National Tutoring Programme and the time required to engage with it, with some headteachers also highlighting problems with the quality and availability of tutors.^{53,54,55}

Of the programme’s three strands, the one in which schools are able to source their own tutors has proved far more popular than those administered in 2021–22 by recruiting firm Randstad. (In March 2022 Randstad was axed from the contract for future academic years, owing to poor take-up of the two strands it was responsible for.⁵⁶)

The government had an overall target of 2 million courses taken under the National Tutoring Programme in 2021–22.⁵⁷ The government does not publish figures on course completions, but high take-up of the school-led strand meant that, as of 26 June 2022, an estimated 1.8 million courses had been started in the 2021–22 academic year. This is around 90% of the government’s target, if every course that was started was completed.⁵⁸

Figure 6.10 National Tutoring Programme course starts during 2021–22 by strand



Source: Institute for Government analysis of DfE, 'National Tutoring Programme: June 2022', course starts table, supported by CIPFA; targets come from government and NTP announcements, NTP contracts and press reporting. Notes: Targets are for the full academic year and relate to courses delivered while performance shown is in terms of courses that had been started as of 26 June 2022; the school-led strand was new in 2021–22; school-led figures and the 2021–22 total are a DfE estimate; targets for the academic mentor and tuition partner strands in 2021–22 are those set at the start of the contract, funding has subsequently been transferred from these strands.

In a survey of participating schools carried out by the National Tutoring Programme in autumn 2021, of those that responded a majority reported that it was having a positive impact on attainment.⁵⁹ A formal evaluation of the first year of the programme has been delayed and will be published in autumn 2022.⁶⁰

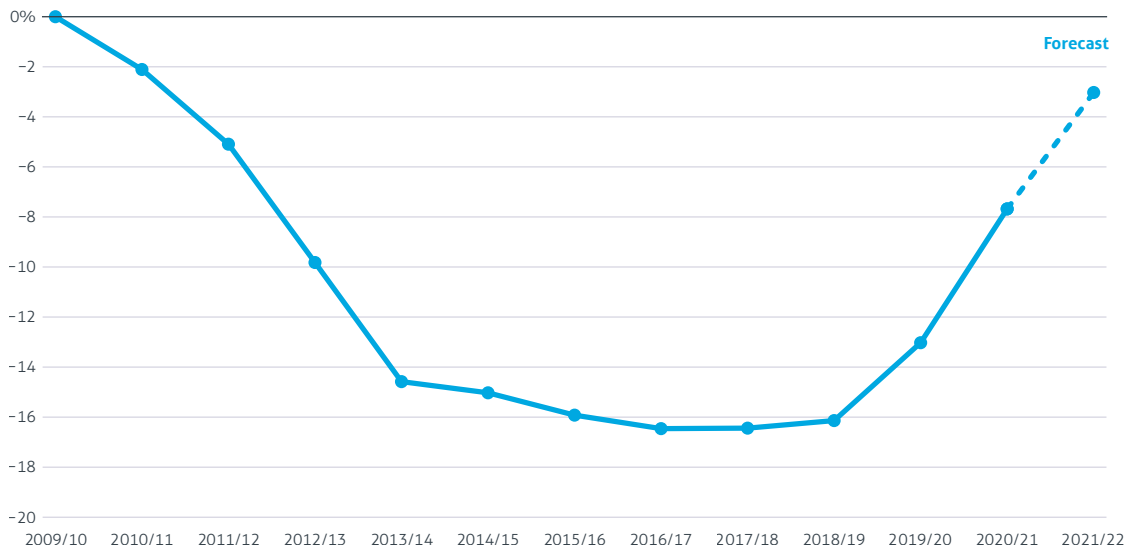
7. Police

Police work is returning to pre-pandemic patterns, with less focus on non-crime activity such as anti-social behaviour, though this still takes up more police time than a decade ago. Total crime is at historically low levels but the picture over the past year is less clear due to recent methodology changes within police forces.

Looking ahead, police forces must begin integrating large numbers of newly recruited officers, the result of the Johnson government's 2019 recruitment drive to add 20,000 officers by 2023, while managing shortfalls that remain in some localities and key areas such as fraud and investigations. Further, despite the increase in officer numbers, the proportion of recorded crimes being charged is at its lowest ever level and confidence in the police has fallen. This chapter covers the 43 police forces in England and Wales as the Home Office is responsible for policing in both nations. We present data on the police in both countries.

Police spending has risen in recent years but is still lower than in 2009/10

Figure 7.1 Change in gross police spending since 2009/10 (real terms)



Source: Institute for Government analysis of DLUHC, 'Local authority revenue expenditure and financing in England' and 'General fund revenue account: police outturn', and StatsWales, 'Revenue outturn expenditure summary', 2009/10–2020/21, supported by CIPFA. Notes: See Methodology for full details of the 2021/22 forecast.

Most of the funding for policing in England and Wales comes from central government grants, with around a third coming from local taxation through a council tax levy known as the 'police precept'. In 2020/21, £15.1 billion was spent on policing in England and Wales; this was 6.4% more in real terms than in 2019/20.¹

A large part of this increase came from the government drive to recruit more officers, which increased spending by £700 million in 2020/21,² with a further £400m allocated for 2021/22.³ The government also set aside an additional £58m to support Covid-related costs including overtime, bringing the total additional funding available to the police for Covid to £200m since the start of the pandemic.⁴

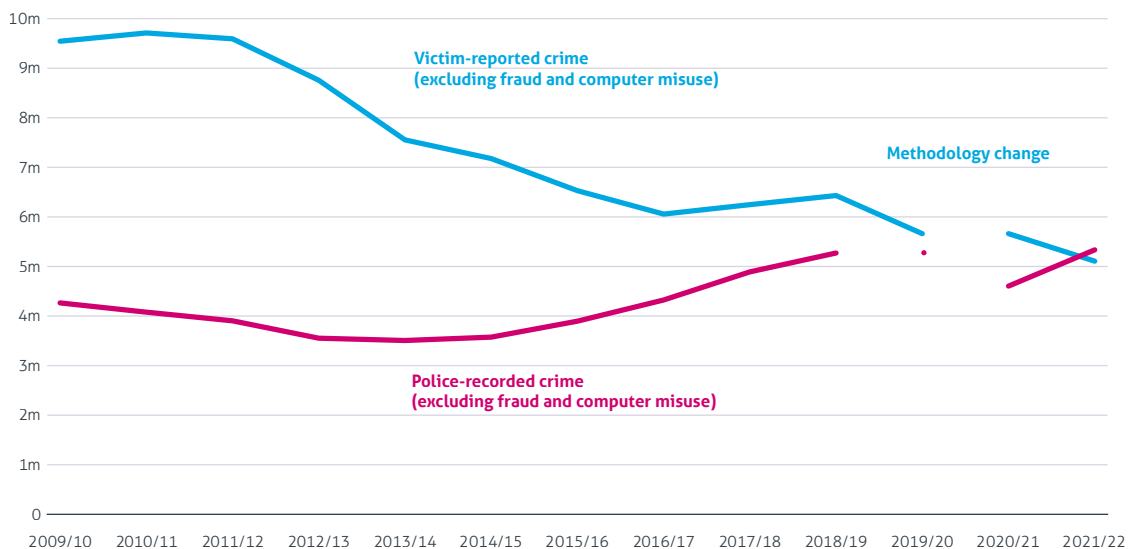
Policing responsibilities are returning to pre-pandemic levels

The nature of police work changed during the height of the pandemic, especially during lockdowns. First, there was a dramatic fall in traditional 'volume crimes' such as theft and burglary. Second, police increasingly focused on non-crime activities such as anti-social behaviour and mental health-related incidents, acting as 'the service of last resort' as other front-line services withdrew.⁵

However, neither of these trends was new. For example, while there was a 13.4% fall in recorded incidents of burglary between 2013/14 and 2019/20, there was a 65% increase in missing persons work over the same period.⁶ But both were accelerated in the first year of the pandemic. More recently, there is evidence that demands on the police have returned to pre-pandemic levels. Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) noted in May 2022 that while "demand on policing... continues to shift and change, inspectors generally find that practice is back to normal".⁷

Total crime is at historically low levels but the picture over the past year is unclear

Figure 7.2 Incidents of crime excluding fraud and computer misuse, 2009/10–2021/22



Source: Institute for Government analysis of Office for National Statistics, 'Crime in England and Wales: Appendix tables', Table A1 and Table A2; and ONS, 'Recorded crime data at Police Force Area level', 2009/10–2021/22, supported by CIPFA. Notes: Police-recorded crime figures exclude those from the Greater Manchester police force 2019/20, as following the implementation of a new IT system in July 2019, the force was unable to supply data for the period July 2019 to March 2020. The change in victim-reported crime measurement is detailed in the Methodology chapter.

There are two ways of measuring crime: how many crimes the police record (police-recorded crime) and how many crimes a representative sample of the population report in the Crime Survey for England and Wales (CSEW; victim-reported crime). As fraud data was only recorded from 2015/16 onwards, this is discussed separately below.

The CSEW is a household-based victimisation survey that includes crimes that are not reported to the police and as such is a better indicator of longer-term trends for the crimes it covers.⁸ However, there was a change in methodology that means the data for 2020/21 and 2021/22 is not directly comparable to the pre-pandemic figures. The police-recorded crime figures cover a broader range of crimes, in addition to victim-based crimes, but are heavily influenced by changes in police crime recording practices.⁹

The CSEW shows a sustained long-term decline in crime over the past decade and in the past year. In 2021/22, there were 5,107,000 crimes (excluding fraud), an almost 10% fall on the year before.¹⁰ The main driver of this fall was a 12% fall in theft offences over the period.

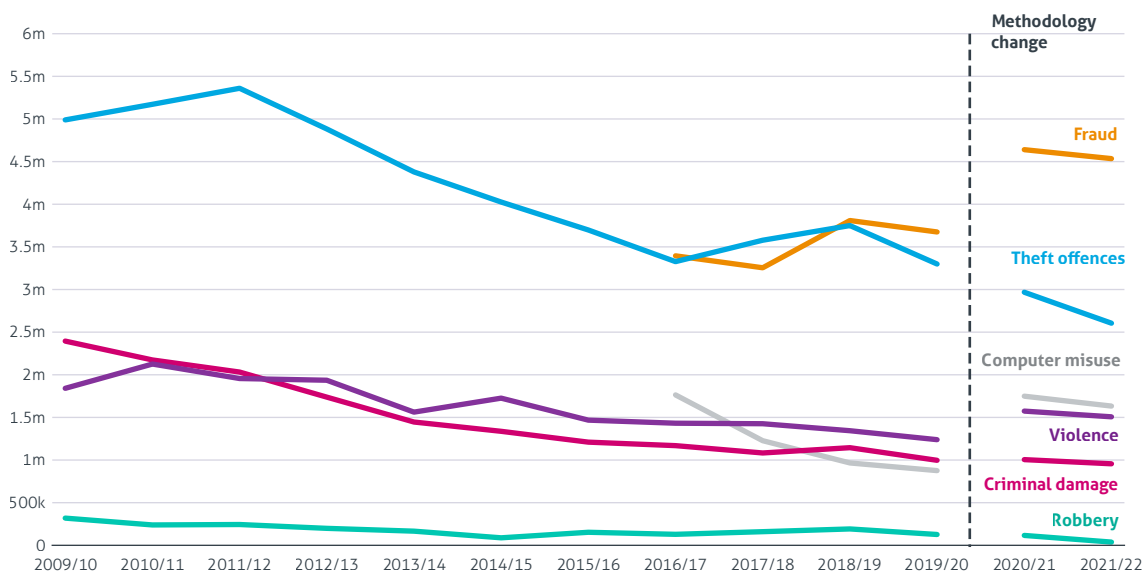
In contrast, after a fall during the first year of the pandemic, police-recorded crime (again excluding fraud) rose in 2021/22, with 5,335,806 crimes, 7% more than in 2019/20.¹¹ We cannot say for certain which data source better reflects crime trends over the past year but it is likely that overall crime (excluding fraud) has fallen and that the rise in police-recorded crime is largely due to improvements to police recording practices, particularly of crimes reported by professional third parties such as social services.¹²

Incidents of fraud remain high but fell slightly in 2021/22

The increasing role of digital technology in society has transformed the nature of crime. Many crimes have shifted online and carried out by criminals overseas that are difficult for police forces to reach.¹³

The CSEW started reporting on fraud in 2015/16 and since then levels of fraud and online crimes remain high.¹⁴ The survey identified approximately 4.5 million victim-reported fraud crimes in 2021/22, though this was 100,000 fewer than 2020/21.¹⁵

Figure 7.3 **Victim-reported crime by type, 2009/10–2021/22**

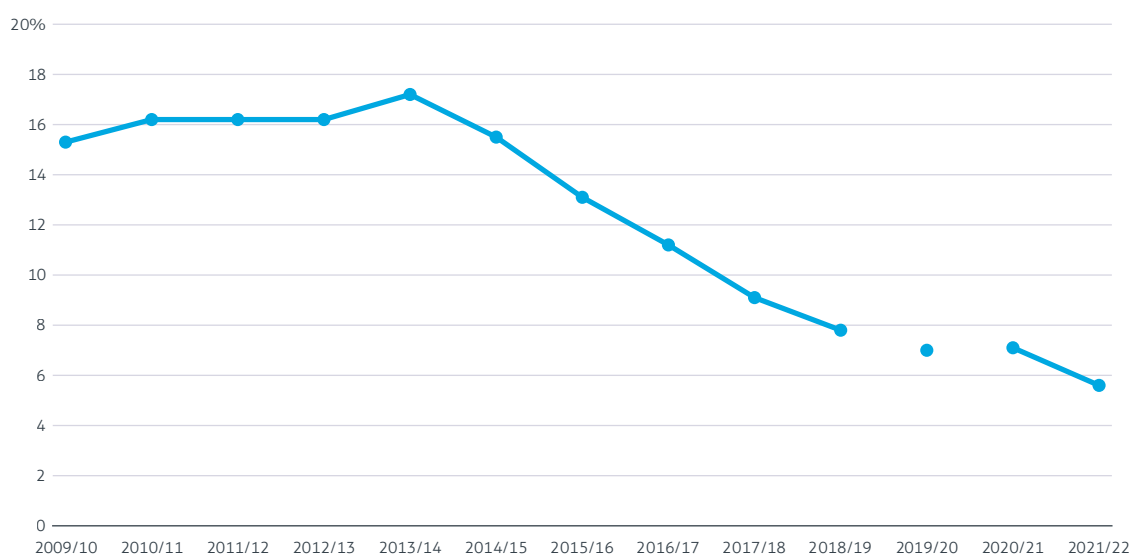


Source: Institute for Government analysis of Office for National Statistics, 'Crime in England and Wales: Appendix tables', Table A1 and Table A2, 2009/10–2021/22, supported by CIPFA. Notes: The crime survey for England and Wales has only recorded fraud victimisation since October 2015. The change in victim-reported crime measurement is detailed in the Methodology chapter.

Despite the high levels of fraud and other online crimes, the Police Foundation's strategic review of policing in England and Wales criticised the scale of police response, noting from the estimated 4.6 million fraud cases in 2020/21 there were only 4,853 charges or summons over the same period.¹⁶ The review also highlighted the digital skills gap in many police forces including areas such as digital forensics and data analysts.¹⁷

Charge rates have fallen further

Figure 7.4 Crimes recorded by the police that result in charges, 2009/10–2021/22



Source: Institute for Government analysis of Home Office, 'Crime outcomes in England and Wales,' Table 2.2, 2009/10–2021/22, supported by CIPFA. Notes: 2019/20 figures exclude Greater Manchester police force data, as following the implementation of a new IT system in July 2019, the force was unable to supply data for the period July 2019 to March 2020.

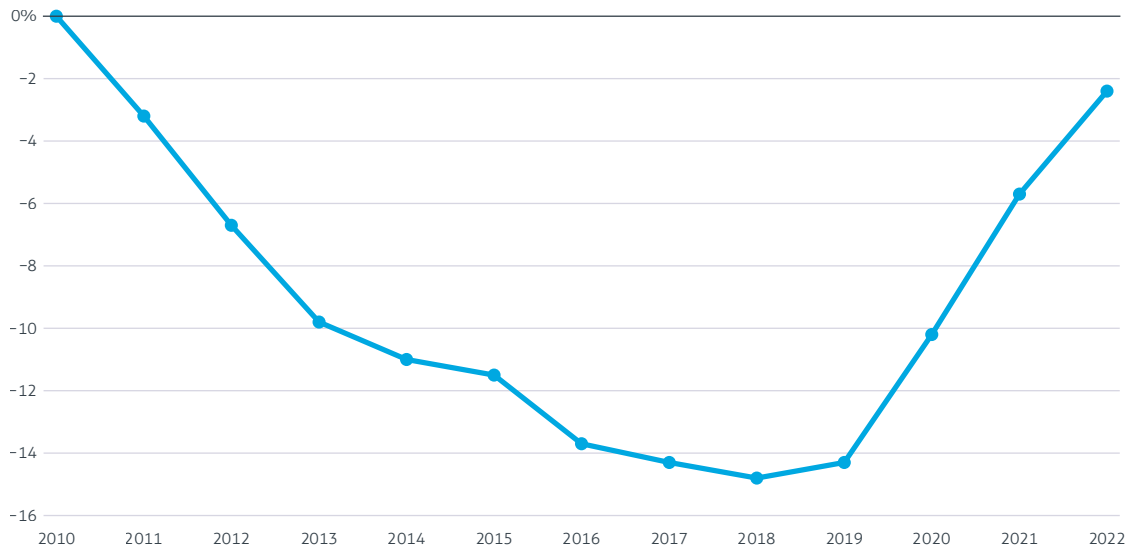
The proportion of recorded crimes that result in charges rose slightly in 2020/21 but fell to a new low of 6% in 2021/22, continuing the decline since 2014/15.¹⁸ This trend has partly been driven by the increase in volume of crimes recorded (as above), but also the continued fall in the absolute number of charges. These have continually fallen since 2014/15 and fell 12.7% between 2020/21 and 2021/22 (from 417,751 to 364,799).¹⁹ In a highly critical report, HMICFRS attributed low charge rates for burglary, robbery and theft down to prioritisation, a lack of capacity, poor digital forensic capability and insufficient supervision.²⁰

Charging rates are low and have fallen particularly sharply for some types of crime. For example, between 2014/15 and 2021/22 the charge rate for sexual offences, including rape, fell from 11.3% to just 2.9%.²¹ The government's end-to-end review of rape in England and Wales described this as a totally unacceptable situation and attributed it to complex factors such as increasing levels of digital data requested from victims, a national shortage of detectives and delays in investigative processes.²² It also called for significantly greater levels of support for victims.²³

The number of officers has increased but the government is not on track for its recruitment target

As of June 2022, there were 142,759 officers, 2.4% fewer than March 2010.²⁴ But this is still a sharp increase from the lows of the mid to late 2010s after the government committed in 2019 to a net increase of 20,000 officers by 2023.

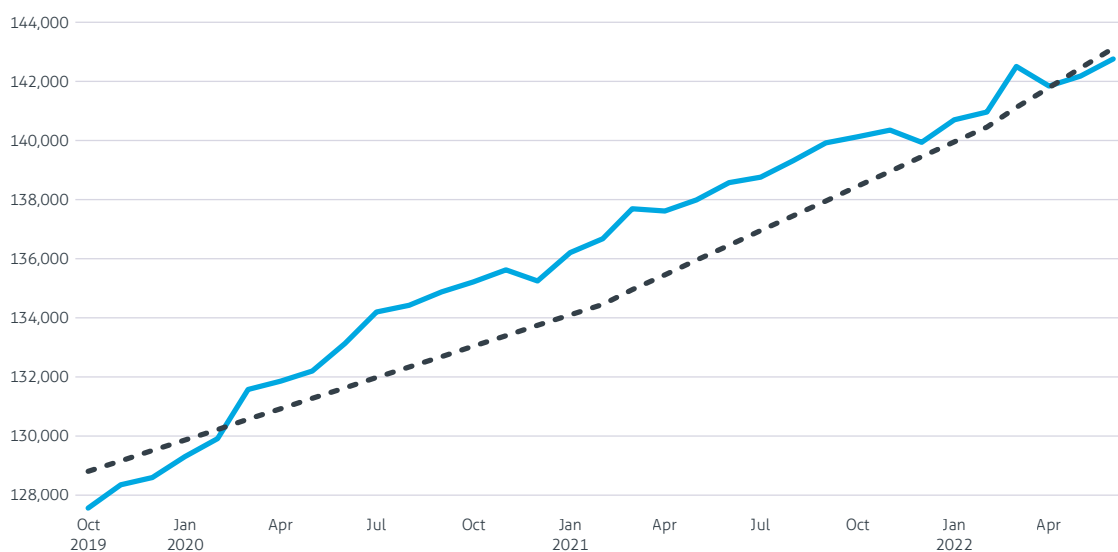
Figure 7.5 Change in police officer numbers since 2010



Source: Institute for Government analysis of Home Office, 'Police officer uplift', Table U1, October 2019–June 2022, supported by CIPFA. Notes: Figures are as at 31 March of the relevant year and cover all officers recruited including those not directly recruited through the officer uplift programme.

By June 2022 the so-called police uplift programme launched in July 2019 had recruited 13,790 new officers.²⁵ The National Audit Office reports that the total spend on the police uplift programme is expected to be £3.6bn by March 2023 if the programme delivers on budget.²⁶

Figure 7.6 Police officer headcount, October 2019 to June 2022



Source: Institute for Government analysis of Home Office, 'Police officer uplift', Table U1, October 2019–June 2022, supported by CIPFA. Notes: Figures are shown from the beginning of the police uplift programme and include both police officers recruited through the police uplift programme and those recruited through other streams; the analysis spreads each annual target over the 12 months of the year.

In May and June 2022, the programme started to fall below its target and extra effort will be required to meet the target of 8,000 additional new officers in 2022/23. A Public Accounts Committee report noted the more difficult labour market conditions facing the programme with many vacancies across the economy and some recruits deterred by declining confidence in policing.²⁷ An increase in officers leaving the force (discussed below) will make this situation yet more difficult.

Constabularies still lack a representative workforce and key skills

A National Audit Office review found that parts of the new intake do not meet current local or future policing needs.²⁸ For example, there continue to be shortfalls in specialist policing areas such as intelligence and investigations.²⁹ The Police Foundation identified a shortfall of 6,851 accredited investigation detectives in 2021 with only 76% of accredited posts filled (though when trainees are factored in, this rises to 93%).³⁰ In the short term this has an impact on workloads and timeliness, and leads to de-prioritisation of some types of crime – such as burglary, assault and theft.³¹ Forces themselves also recognise a lack of digital and digital forensics skills.³²

Increasing police numbers has not adequately addressed the under-representation of minority ethnic groups in the police force noted by the Home Affairs Committee in 2021.³³ By the end of June 2022, just 1.6% of all new officers recruited since April 2020 were Black³⁴ – approximately half the size of the Black population in England and Wales.³⁵ It also does not suggest police forces have been particularly successful in attempts to bring this rate up as the existing proportion of Black officers nationally stands at 1.3%.³⁶

Police retention worsened in 2021/22 amid high levels of pay dissatisfaction

Throughout the pandemic, the police have faced difficult working conditions that may have impacted wellbeing. The recent strategic review highlighted harder work with longer shifts and unique challenges – such as members of the public threatening to infect officers with Covid – as factors adding to police stress.³⁷ Despite this, police turnover stabilised during 2020/21.³⁸ However, this trend reversed in 2021/22 with a 35% increase in officers leaving the force. The total number of officers leaving was higher than in 2019/20, though below the high of 2018/19.³⁹

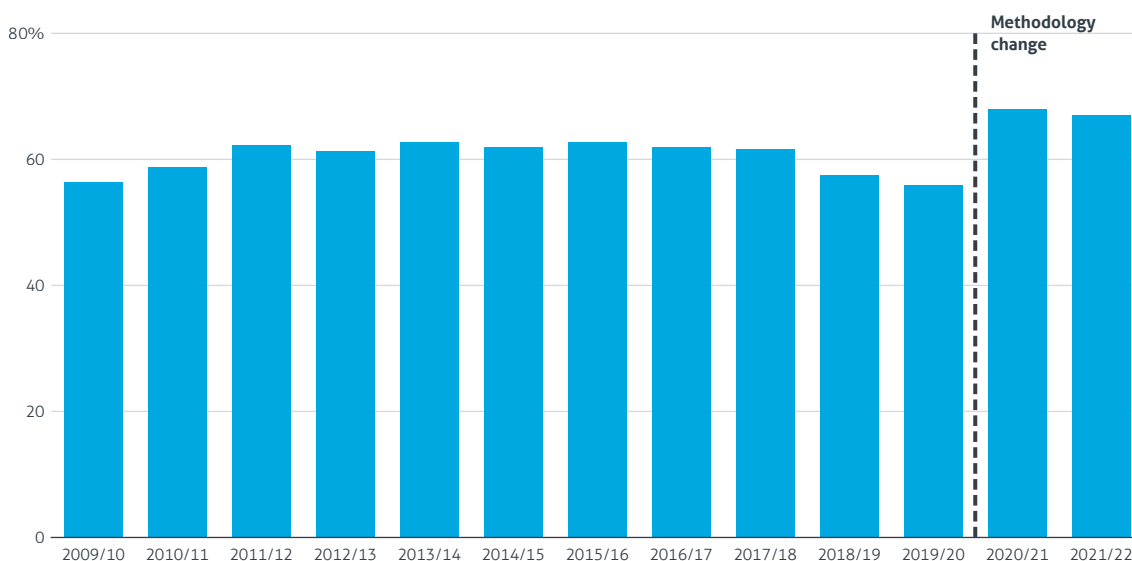
In the medium term, there may be further retention problems. The December 2021 Police Federation pay and morale survey found high levels of pay dissatisfaction, with this increasing to 82% in 2021, up from 69% in 2020.⁴⁰ Surveyed even before double-digit inflation hit in 2022, almost all respondents (92%) said that pay increases would not maintain their standard of living.⁴¹ Police forces have little financial headroom as the police uplift programme is financed by central government for only the first three years, after which costs fall to forces.⁴²

There is declining public confidence in policing

There is a wide range of survey evidence suggesting that public confidence in and satisfaction with police performance has fallen over recent years.

Most respondents to the CSEW report their local police are doing a good or excellent job. However, the number doing so declined from a high of 63% in 2015/16 to a low of 56% in 2019/20. A change to telephone-based interviews make recent years non-comparable but they too show a decline between 2020/21 and 2021/22.

Figure 7.7 **Public perception that local police are doing a good or excellent job, 2009/10–2021/22**



Source: Institute for Government analysis of Office for National Statistics, 'Crime in England and Wales: Annual supplementary tables', Table 2, 2015/16–2019/20; ONS, 'Crime in England and Wales: coronavirus (COVID-19) and crime tables', Table 5, Year ending March 2022; supported by CIPFA. Notes: Full details of the methodology change are explained in the Methodology chapter.

Similarly, data from YouGov asking about policing in general indicates a marked loss of confidence. Averaging figures over a 12-month period in a survey carried out between July 2020 and June 2021, close to half (46%) of respondents said they either had not very much or no confidence at all in the police to deal with crime, compared to 39% a year earlier.⁴³ Similarly, in a different survey averaged figures over the same time period show 57% of respondents felt the police were doing a good job compared to 70% a year earlier.⁴⁴

This deterioration in attitudes in policing in general is likely to be linked to several high-profile policing scandals in 2021/22. For example, in July 2022, HMICFRS placed the Metropolitan Police under special measures after 'substantial and persistent' concerns, including poor handling of the Stephen Port case, the murder of Sarah Everard, the strip search of three children including Child Q and unprofessional behaviour at Charing Cross police station.⁴⁵

Trust among minority groups is even lower. A YouGov poll in October 2021 identified that only 44% of minority ethnic Britons trust the police, down from 52% in October 2020.⁴⁶ This finding matters given continued disproportionate use of stop and search powers which, HMICFRS notes, causes suspicion among communities that they are being unfairly targeted.⁴⁷ HMICFRS identified using 2019/20 data that Black people were about 5.7 times more likely to have force used on them than their white counterparts.

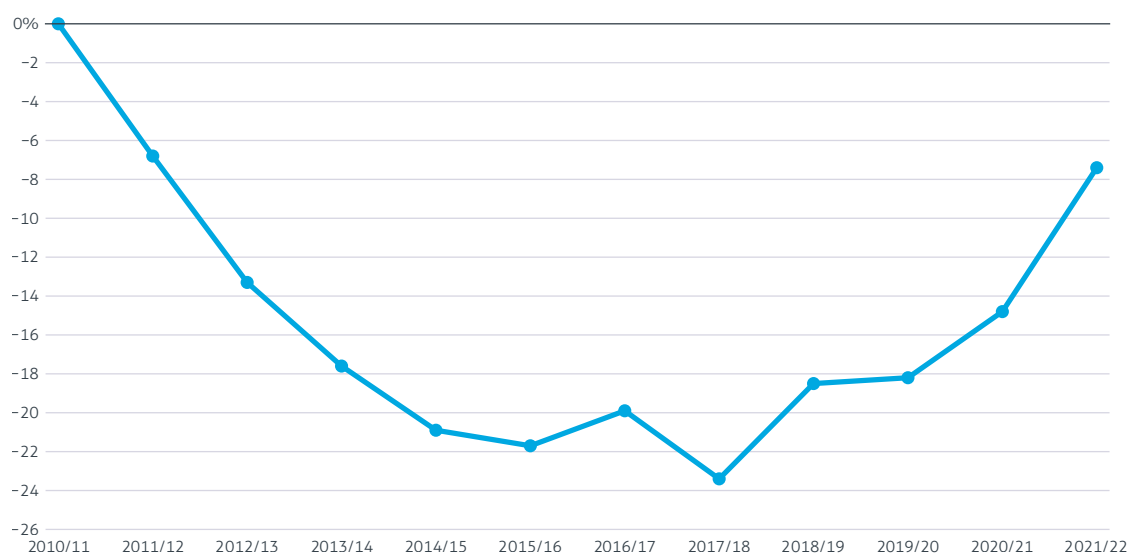
8. Criminal courts

Criminal courts, and especially the crown court, which deals with the most serious cases, have had their capacity to hear cases badly affected by the pandemic. Covid restrictions led to a sharp increase in the backlog of cases waiting to be heard. This did not begin to fall until June 2021 and will remain far above pre-Covid levels for several years. In 2021/22, the courts were still not operating as efficiently as before the pandemic, and a shortage of judges and barristers will restrict how quickly the courts in England and Wales can process cases to reduce the backlog.

Spending on courts increased in response to Covid but remains low in historical terms

During 2020/21 and 2021/22, Her Majesty's Courts and Tribunal Service (HMCTS), which is responsible for civil courts and tribunals as well as the criminal courts, received additional funding to help adjust its working during the pandemic and address its consequences. In 2021/22, additional funding for cleaning, temporary courts and extra technology came to £78 million.¹ Covid-related funding accounted for around 3% of HMCTS's £2.4 billion budget in 2021/22.* Spending was 21% higher than the low point of 2017/18, but still below the 2010/11 budget in real terms despite a record backlog and a need to process more cases.

Figure 8.1 Change in Her Majesty's Courts and Tribunal Service spending since 2010/11 (real terms)



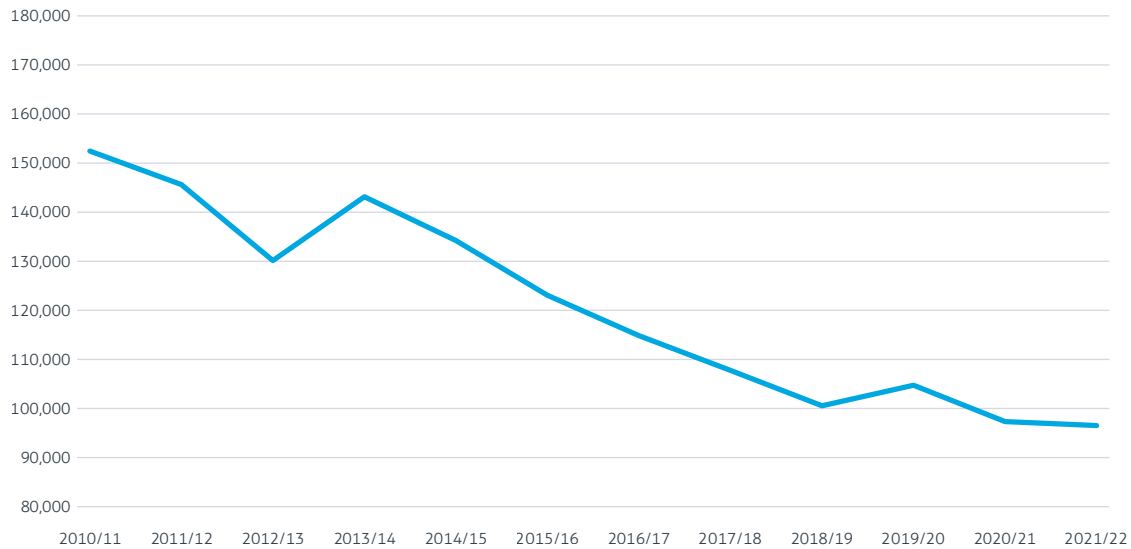
Source: Institute for Government analysis of various HMCTS annual reports and accounts, supported by CIPFA. Notes: 2010/11 is the first full year after HMCTS was formed.

* HMCTS also receives some fee income for civil court and tribunal cases, but not for criminal cases. Around three fifths of the £2.4bn was spent on criminal courts.

The number of cases criminal courts had to deal with fell during the pandemic and has not yet fully recovered

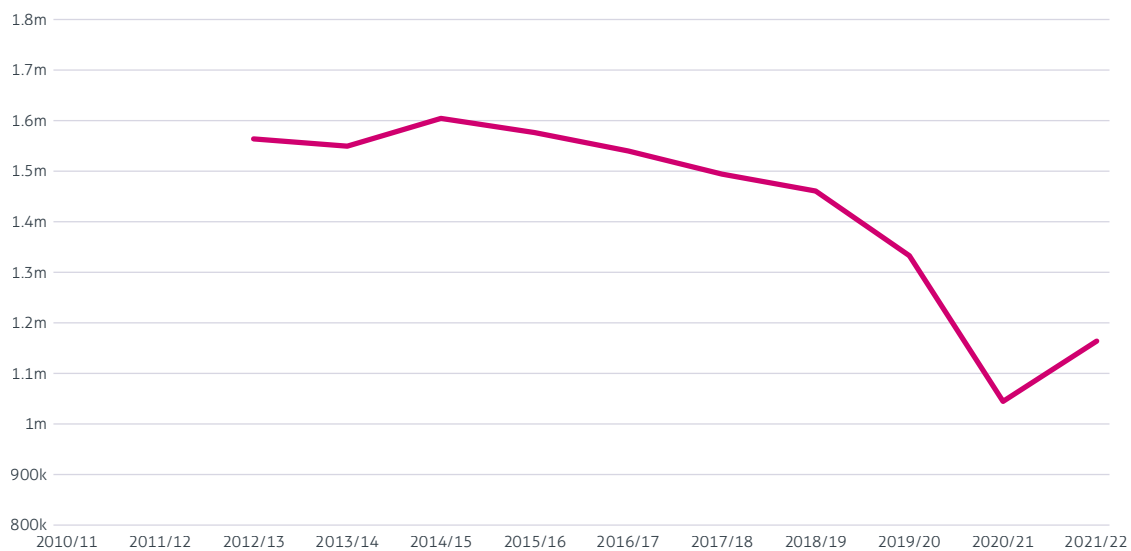
Demand in the criminal courts is best measured by the number of new cases entering the court system. All criminal cases first enter the magistrates' courts. Most stay there with only the most serious cases being passed on to the crown court.

Figure 8.2 Cases received by the crown court, 2010/11–2021/22



Source: Institute for Government analysis of Ministry of Justice, 'Criminal court statistics, January-March 2022', Table C1, supported by CIPFA. Note: Quarterly data is only available from 2010/11.

Figure 8.3 Cases received by magistrates' courts, 2012/13–2021/22



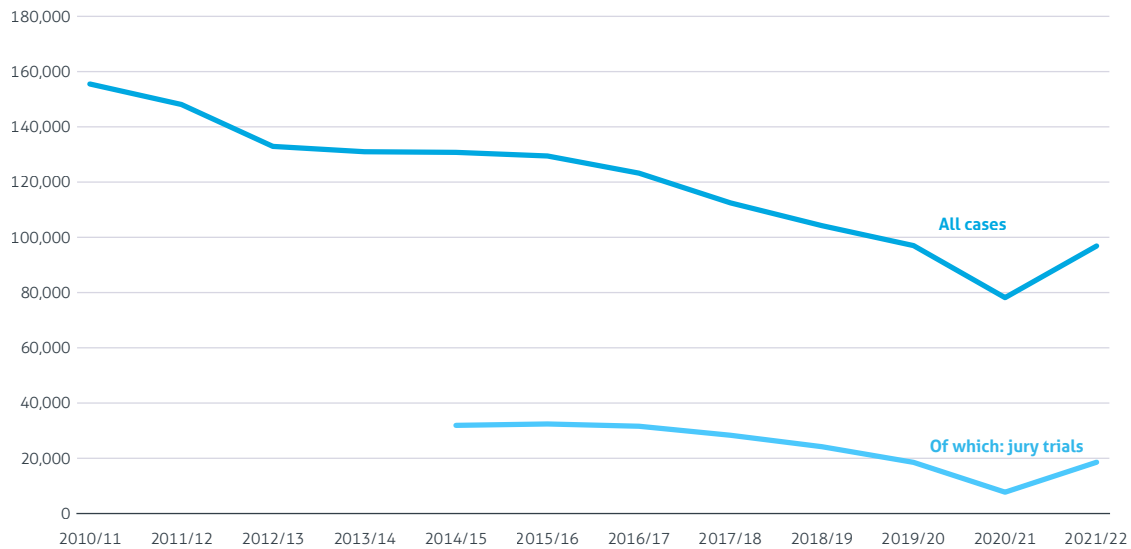
Source: Institute for Government analysis of MoJ, 'Criminal court statistics, January-March 2022', Table M1, supported by CIPFA. Notes: Data is only available from 2012/13.

The number of cases entering the court system has been in constant decline since 2014/15 but fell even further during the pandemic. The decline since the mid-2010s has been attributed to a combination of falling police resources (the number of police fell by 20,000 between 2010 and 2018) and the growing complexity of crime,

which means investigations take longer to conduct.² Lower case receipts during the pandemic can be explained by changing crime patterns and police activity, outlined in the Police chapter. Despite official government projections of growing demand on criminal courts after the pandemic,³ largely due to increasing police officer numbers, this has not yet materialised and demand remains far below mid-2010s levels.

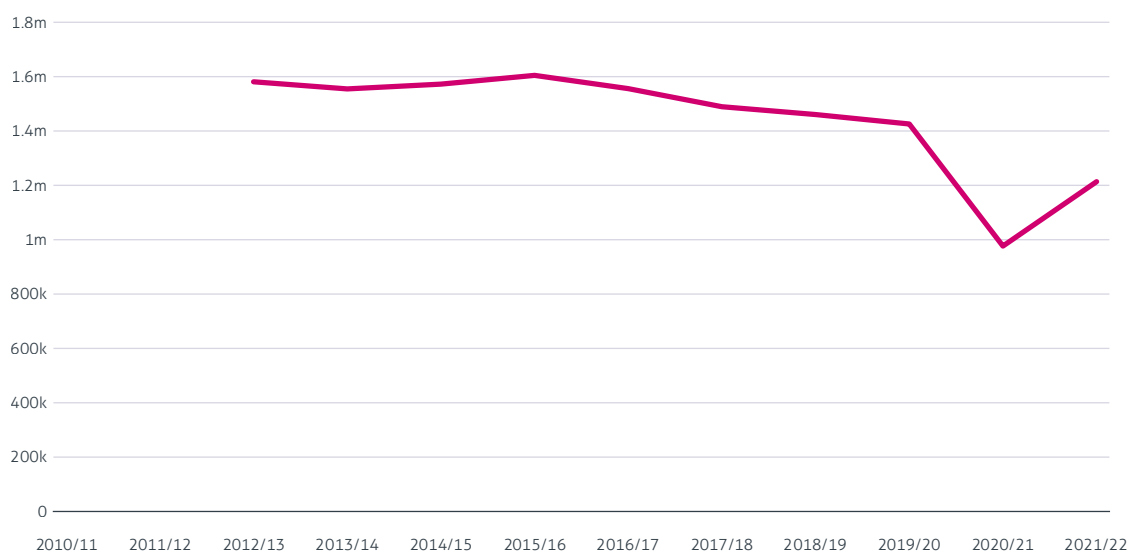
But the courts' capacity to process cases fell by more and remains below the required level to keep pace with future demand

Figure 8.4 Cases processed by the crown court, 2010/11–2021/22



Source: Institute for Government analysis of Ministry of Justice, 'Criminal court statistics January-March 2022', Table C1, supported by CIPFA. Notes: Quarterly data is only available from 2010/11; most cases in the crown court do not require a jury trial, either because the defendant pleads guilty or because it is a sentencing or appeal decision from the magistrates' court; this chart shows the total number of cases disposed and the number that are jury trials.

Figure 8.5 Cases processed by magistrates' courts, 2010/11–2021/22



Source: Institute for Government analysis of Ministry of Justice, 'Criminal court statistics January-March 2022', Table M1, supported by CIPFA. Note: Quarterly data is only available from 2012/13.

The courts' ability to process cases was still low in 2021/22. In both the magistrates' and crown courts, the number of cases completed fell dramatically in 2020 owing to the pandemic. Initially hearings could not be held in person, and while some cases could be heard online, trials – especially jury trials – needed to take place in person. Social distancing restrictions limited use of courtrooms for most of 2021/22⁴ and the number of cases – and jury trials – processed by the crown court in particular did not match up to the government's recovery plan, disposing of fewer cases than in 2019/20.⁵

Courts were less efficient in 2021/22 than before the pandemic

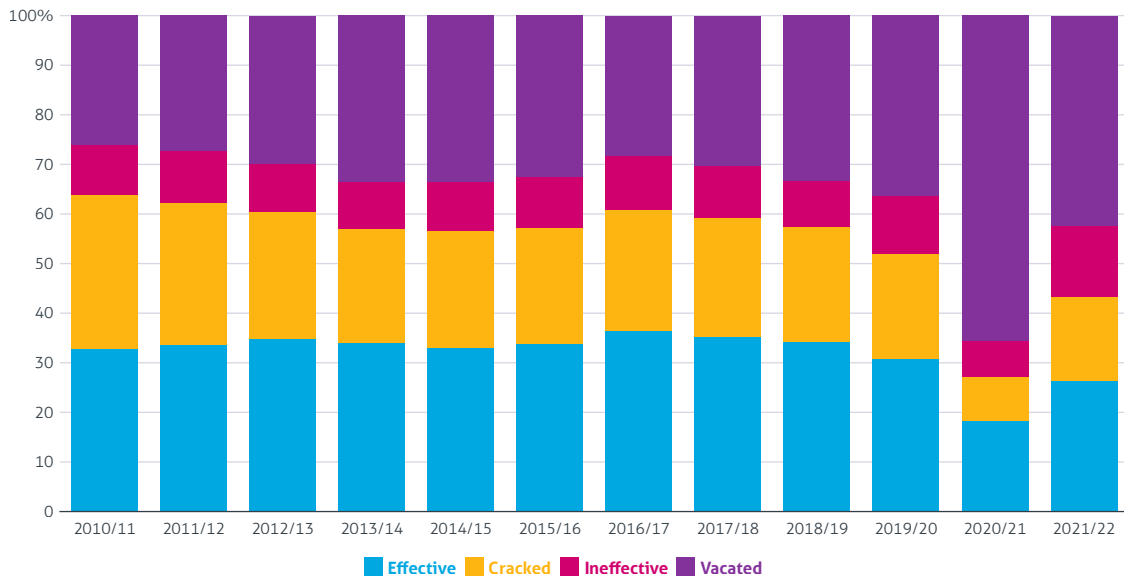
The failure of criminal courts to process more cases in 2021/22 does not reflect a lack of spending or resources but instead a less efficient system.

Cases that are listed for trial can have four outcomes, as laid out by HMCTS: they can be **effective**, meaning the trial occurs as planned; **cracked**, meaning the trial need not happen but this is only decided on the day; **vacated**, meaning the trial is delayed but ahead of time so another trial can be listed in its place; or **ineffective**, meaning the trial does not happen on the day and needs to be rearranged.

During 2020/21, a much higher share of cases than usual were vacated due to the impact of coronavirus restrictions. However, in 2021/22, while the vacation rate has been higher than usual, a higher share of trials have also been ineffective – the worst outcome – than before coronavirus in both magistrates' and crown courts. The single biggest contributor to this has been 'defendant illness or other unavailability': almost 5,000 cases across both courts were ineffective for this reason in 2021/22, compared with fewer than 2,000 in 2019.⁶

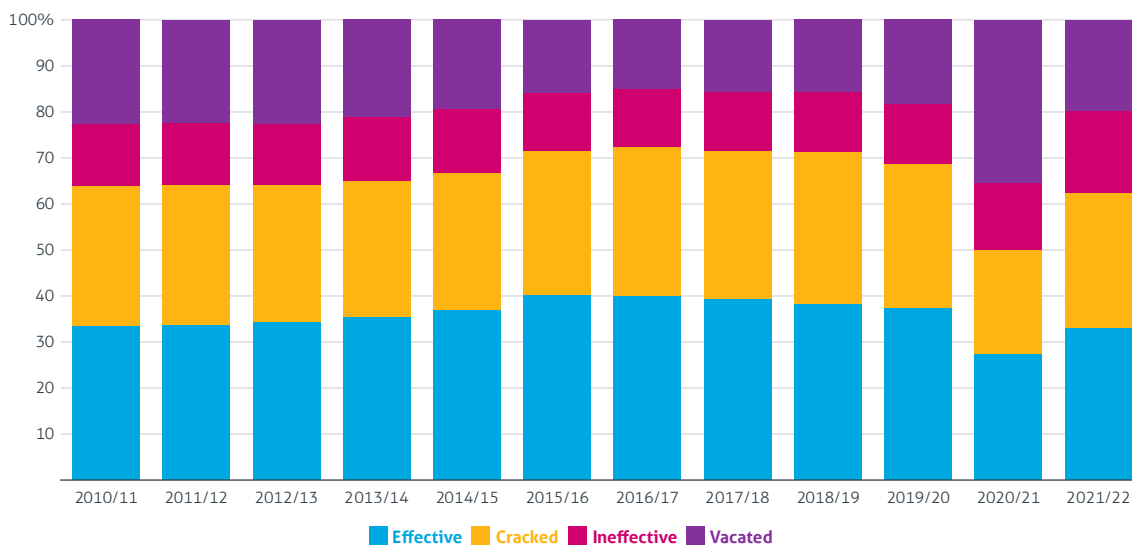
When trials are ineffective or cracked, it means that court time cannot be used effectively because it will often not be possible to find another trial to fill the slot. In the crown court, the number of measured sitting days – that is, the number of days a judge sat to hear cases – was 99,000 in 2021. This was much higher than the reduced 69,000 in 2020 and similar to the 102,000 in 2018.⁷ However, the total amount of time spent hearing cases in 2021 was only 292,000 hours (or 2.9 hours per sitting day), compared with 359,000 hours (or 3.5 hours per sitting day) in 2018, showing that the courts have made less use of the available court time.⁸ We understand this is in part due to Covid restrictions, which increased the downtime between hearings due to social distancing and additional cleaning.

Figure 8.6 Trial effectiveness in the crown court, 2010/11–2021/22



Source: Institute for Government analysis of MoJ, 'Criminal court statistics January-March 2022', Table C2, supported by CIPFA.

Figure 8.7 Trial effectiveness in magistrates' courts, 2010/11–2021/22



Source: Institute for Government analysis of MoJ, 'Criminal court statistics January-March 2022', Table M2, supported by CIPFA.

During the pandemic, courts made widespread use of remote hearings – video and audio technology – to avoid in-person interactions. These have continued beyond formal pandemic restrictions, but mostly for short routine hearings rather than substantive ones.⁹ Short, routine hearings account for a relatively small share of court time and so there is a limit to how much of an efficiency gain this new technology can provide. In any case, the consensus among interviewees and a survey of magistrates is that remote hearings do not help courts run more efficiently,¹⁰ although they can provide a benefit to barristers who would otherwise need to travel to attend short hearings. No data has been published by HMCTS on the prevalence of remote hearings since May 2021,¹¹ although interviewees told us that they are used much more readily by some judges and in some jurisdictions than others.

Adjusting for complexity the backlog is twice as large as before Covid and falling slowly

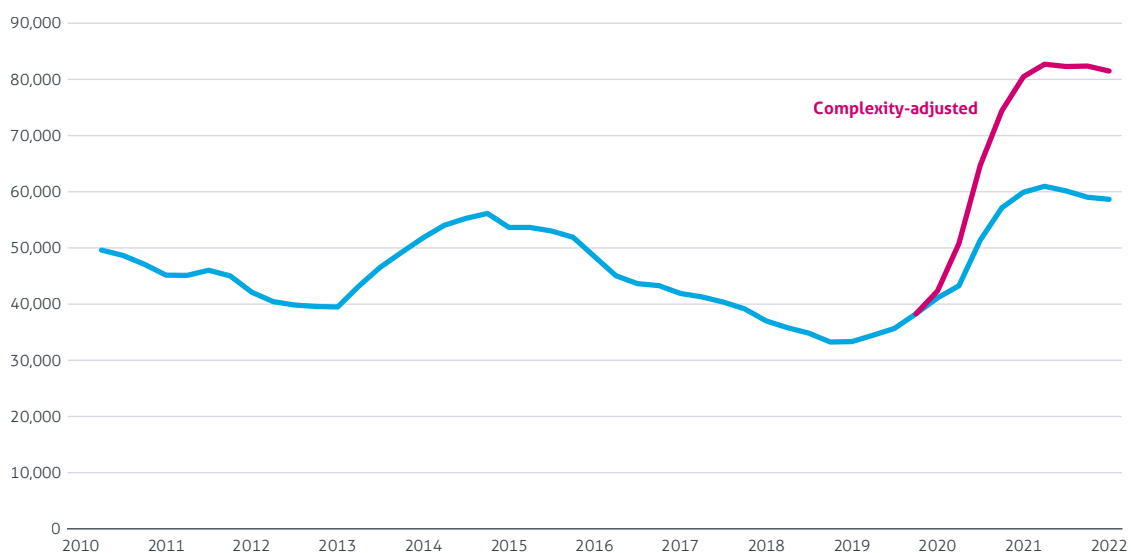
The big fall in the number of cases processed during 2020 – a fall in capacity that outweighed the smaller fall in demand – led to a big increase in the number of cases in the system waiting to be dealt with.

In the magistrates' courts, the backlog initially increased substantially, but a combination of lower demand (including fewer motoring and other less serious offences, which account for over three quarters of the caseload), use of remote hearings and no jury trials being required meant that the backlog quickly began to fall from Q3 2020.

The situation in the crown court is much more difficult. Capacity fell much further during the pandemic because jury trials could not be held at all in Q2 2020 and were affected by social distancing requirements thereafter. The backlog peaked at more than 60,000 cases in June 2021, the highest on record, before falling by 2,000 cases over the next two quarters. The government's official plan is to reduce the backlog to 53,000 cases by November 2024,¹² which would mean cases remaining far above the pre-crisis level of below 40,000 for a long time. So far, the backlog is falling fast enough for the courts to achieve this, but if demand increases as expected the current rate of processing cases would not be sufficient.

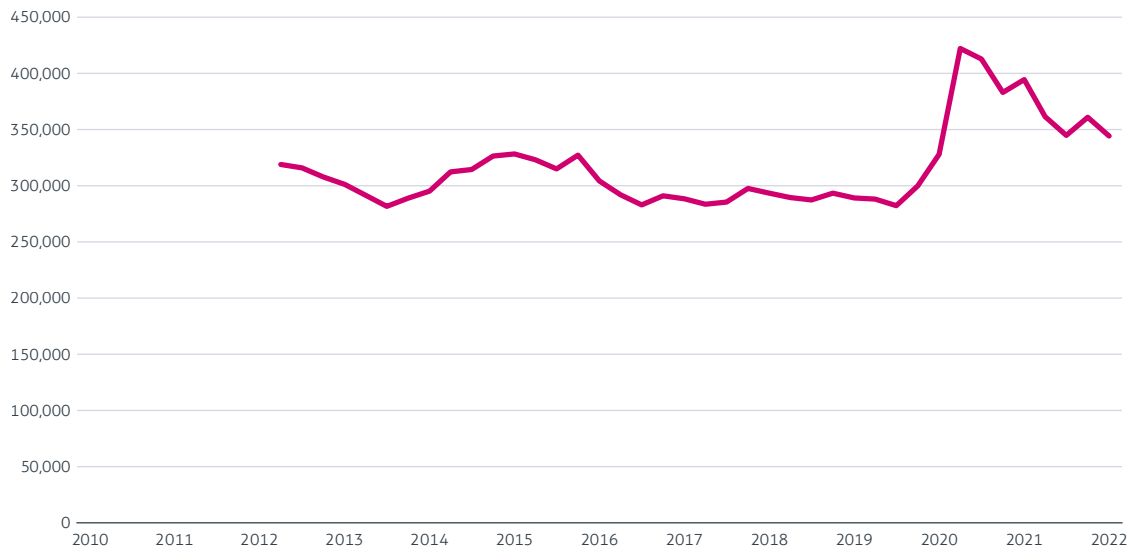
The headline backlog figure also understates the scale of the problem. The cases that could not be heard during the pandemic were disproportionately jury trials. These account for a minority of cases but most court time as they take much longer than other cases. Adjusting the backlog to account for this additional complexity, the 'true' backlog is twice as large as before the pandemic and has been falling only slowly.

Figure 8.8 **Backlog of cases in the crown court, Q2 2010 to Q1 2022**



Source: Institute for Government analysis of MoJ, 'Criminal court statistics January-March 2022', Table C1, supported by CIPFA. Notes: Complexity-adjusted backlog accounts for the greater share of cases awaiting jury trial in the backlog, as modelled by the Institute for Government; see Methodology for full details.

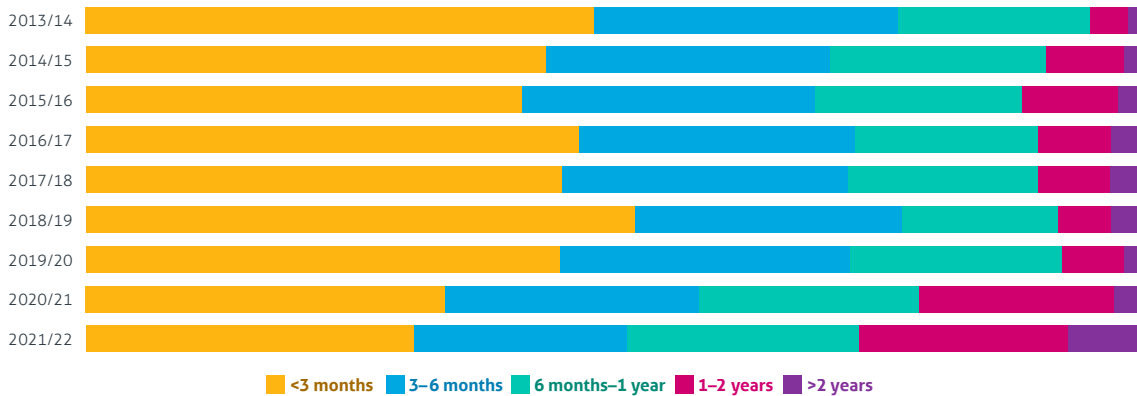
Figure 8.9 Backlog of cases in magistrates' courts, Q2 2010 to Q1 2022



Source: Institute for Government analysis MoJ, 'Criminal court statistics January-March 2022', Table M1, supported by CIPFA.

As a result, victims are waiting longer for justice than at any time on record

Figure 8.10 Waiting times for cases in the crown court backlog, 2013/14–2021/22



Source: Institute for Government analysis of MoJ, 'Criminal court statistics January-March 2022', Table O3, supported by CIPFA.

A big backlog matters because it means people have to wait longer to have their cases heard. At the end of 2021/22, 25% of cases yet to be completed had been in the system for more than a year, compared with less than 10% before the pandemic. Even though the backlog has begun to shrink, waiting times for cases are still increasing.

Long waiting times can undermine justice. It can affect the recollections of witnesses and defendants, and may mean that defendants do not want to fight a case that could last for years. Some defendants are held on remand in prison while they await trial (if they are not granted bail) – a number that has risen since Covid – and it is possible these people will be found not guilty after a long stint in prison.

Shortages of judges and barristers limit how quickly the courts can reduce the backlog, exacerbated by industrial action

Despite the impact of backlogs on the operation of criminal courts, the government is expecting to reduce the backlog only slowly over the next few years. This is not because of a lack of money – the government provided funding for ‘unlimited sitting days’ in 2021/22, which has been continued into 2022/23. Instead, the constraint on the number of cases the courts can process is the availability of judges and barristers.

The number of judges (who oversee all crown court cases) has been relatively stable over the past eight years, but the government is trying to recruit more to enable more cases to be heard. However, in the latest round of recruitment only 52 of 63 vacancies were filled and the Public Accounts Committee does not believe the government’s plan to recruit 78 in the next round is credible.¹³

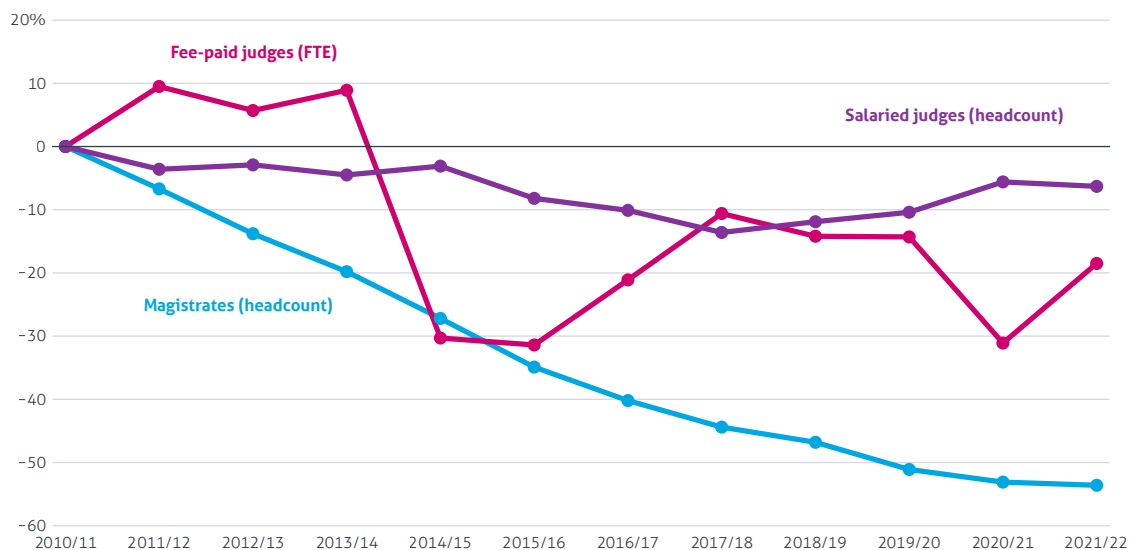
Crown court judges will mostly be recruited from the existing pool of criminal barristers. But this poses a problem, because there is also a shortage there. The number of barristers fell further during the pandemic as defence barristers in particular diversified their portfolios to maintain their income.¹⁴ The rates paid to barristers for criminal cases through legal aid have fallen substantially in real terms since 2010. Combined with lower activity in the courts, this has made criminal defence work poorly paid compared with other legal work, especially early in careers. Spending on criminal legal aid was 41% lower in real terms in 2021/22 than in 2011/12.¹⁵

The Criminal Legal Aid Review reported in 2021 and, among other recommendations, advised rates should be increased by 15%.¹⁶ The government initially acceded to this only for new cases, meaning that most of the cases processed in the next year (which are already in the backlog) would be processed at the old, lower rates.

Barristers took industrial action in response. An initial ‘no returns’ policy (that is, barristers refusing to accept work returned when the initial barrister becomes unavailable) became full strike action with several days of strikes in summer 2022 and an indefinite strike from September 2022. An improved offer from new Secretary of State Brandon Lewis, extending the 15% rise, led barristers to vote to end strike action in early October.¹⁷

Barrister strikes were disruptive while they lasted, so it was important for the sustainability of the courts system that the government was able to agree a deal. The backlog rose between March and June 2022,¹⁸ and a Freedom of Information release from the Ministry of Justice shows that on average fewer than 300 trials were completed per week between April and July, down from an average of more than 350 in 2021/22.¹⁹ An indefinite strike would have been even more disruptive. However, while barristers will now go back to work shortages of this group are likely to continue to limit how quickly the government can process cases to reduce the backlog.

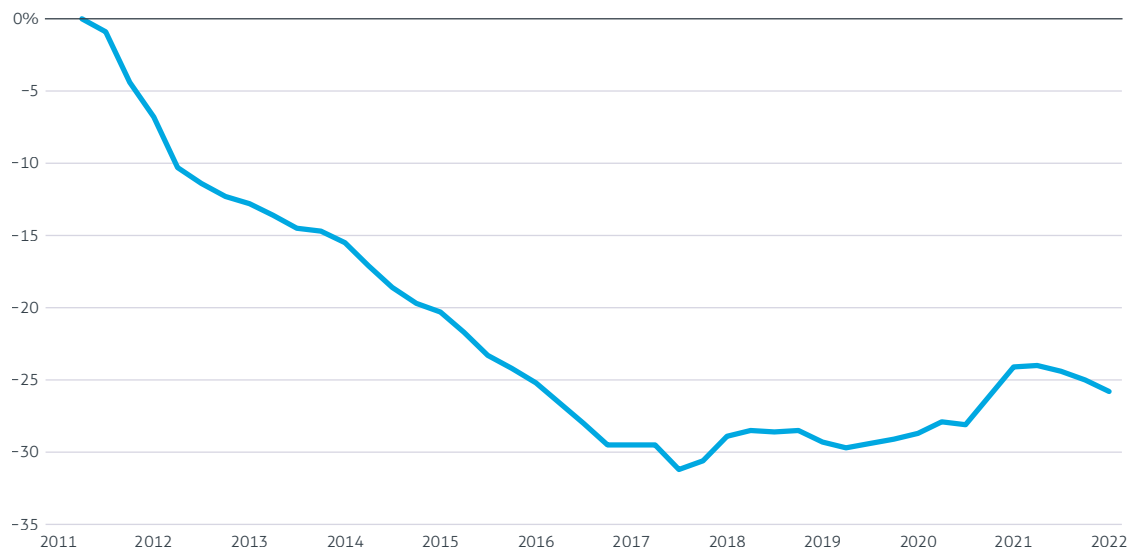
Figure 8.11 Change in the number of judges and magistrates since 2010/11



Source: Institute for Government analysis of HMCTS, *Annual Report and Accounts 2021–22*, supported by CIPFA.

The other relevant workforces for the criminal courts are magistrates and HMCTS staff. Magistrates are volunteers and their numbers have fallen by more than 50% since 2010. Nonetheless, this is not currently a major constraint on how many cases can be processed. Magistrates have managed with reduced numbers by sitting as a panel of two rather than the usual three. HMCTS staff numbers have increased since 2017, and despite a much smaller workforce than 2010 the department believes the workforce is big enough.²⁰

Figure 8.12 Change in the number of HMCTS staff since Q2 2011



Source: Institute for Government analysis of ONS, 'Public Sector Employment, March 2022', supported by CIPFA.

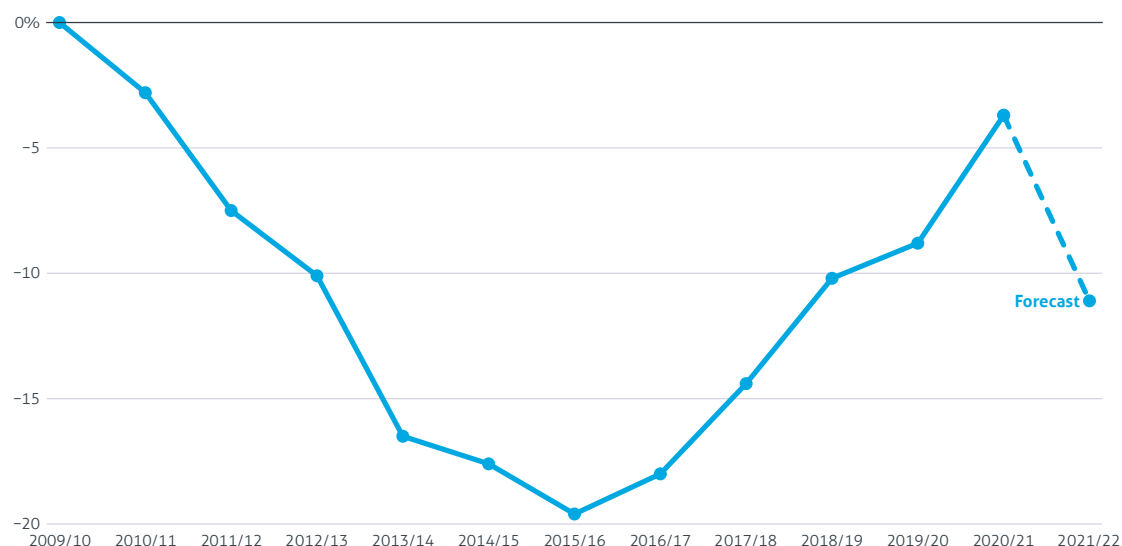
9. Prisons

Prisons have been placed in stringent lockdown regimes throughout the pandemic, and many restrictions are still in place. This successfully limited the spread of Covid and the number of prisoner deaths, but led to several harmful consequences. Long periods spent in cells, delays for routine health appointments and severely reduced access to education, training and work have all harmed prisoners' wellbeing and prospects. And though prison governors have, since May 2022, been able to lift Covid restrictions, the prison workforce is insufficient to do so safely in all prisons, with some prisoners still being kept locked in their cells for most of the day.

This chapter considers the 119 publicly and privately run prisons in England and Wales. Her Majesty's Prison and Probation Service (HMPPS), an executive agency within the Ministry of Justice, runs 105 of these, while Serco, G4S and Sodexo run the remaining 14.

Spending on prisons fell in 2021/22

Figure 9.1 **Change in spending on prisons since 2009/10 (real terms)**



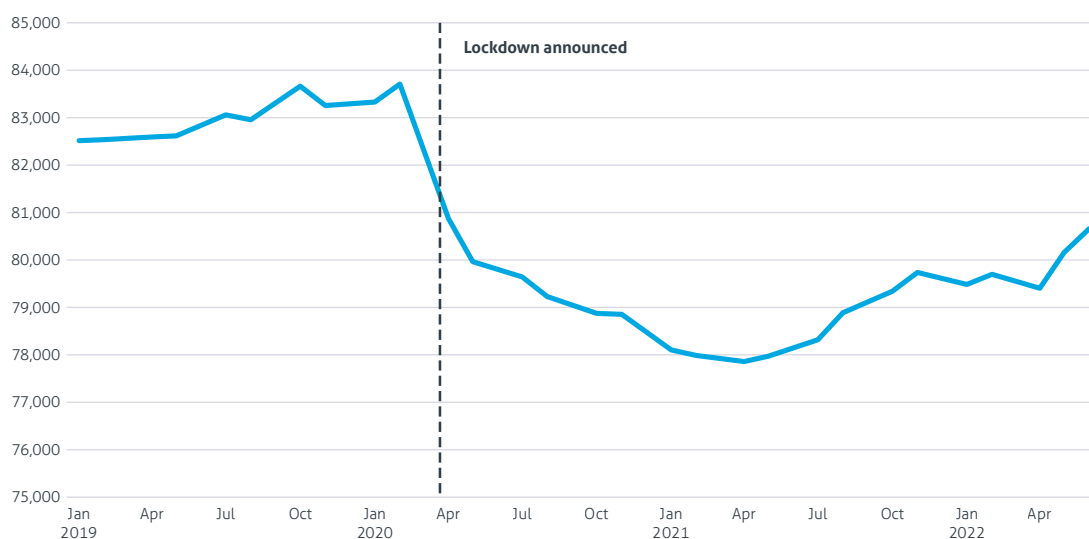
Source: Institute for Government analysis of MoJ, 'Costs per prison place and prisoner by individual prison', 2009/10–2020/21; HM Treasury, 'Central Government Supply Estimates 2021-22: Supplementary Estimates'; supported by CIPFA. See Methodology for how the 2021/22 spending figure was estimated.

Spending on prisons had been increasing since 2015/16 and this trend continued in the first year of the pandemic, when a number of Treasury-approved schemes were implemented to ensure the continued supply of staff and to minimise the risk of unrest. Day-to-day spending rose 5.6% in 2020/21, but was expected to fall by around 8% in real terms in 2021/22 as Covid support measures came to an end.^{1,*}

Investments have been made in the prison estate during the pandemic. In 2020/21, HMPPS bought and installed 1,150 temporary accommodation units to make it easier to spread out and isolate prisoners.² It has also expanded the availability of video and telephone facilities. Video-calling between prisoners and their friends and family was first introduced in March 2020 and all prisons had this capability by the end of the year. Between March 2020 and August 2022, in-cell telephones were installed in 31 establishments, leaving 12 closed prisons³ and 12 open prisons⁴ still to have these installed.

The number of prisoners fell 6% during the pandemic but rose in the first few months of 2022/23

Figure 9.2 Number of prisoners, January 2019 to June 2022



Source: Institute for Government analysis of MoJ, 'Offender management statistics quarterly', Table 1.1 Prison population, 31 January 2019 to 30 June 2022, supported by CIPFA.

The prison population fell substantially at the start of the pandemic and by 6% between March 2020 and July 2021, reducing the total number by nearly 5,000. This was largely due to fewer people being sent to prison as a result of the initial closure of courts and subsequent social distancing requirements, which reduced the number of cases heard. The population remained below 80,000 for all of 2021/22 but had risen above this in the first few months of this financial year.⁵

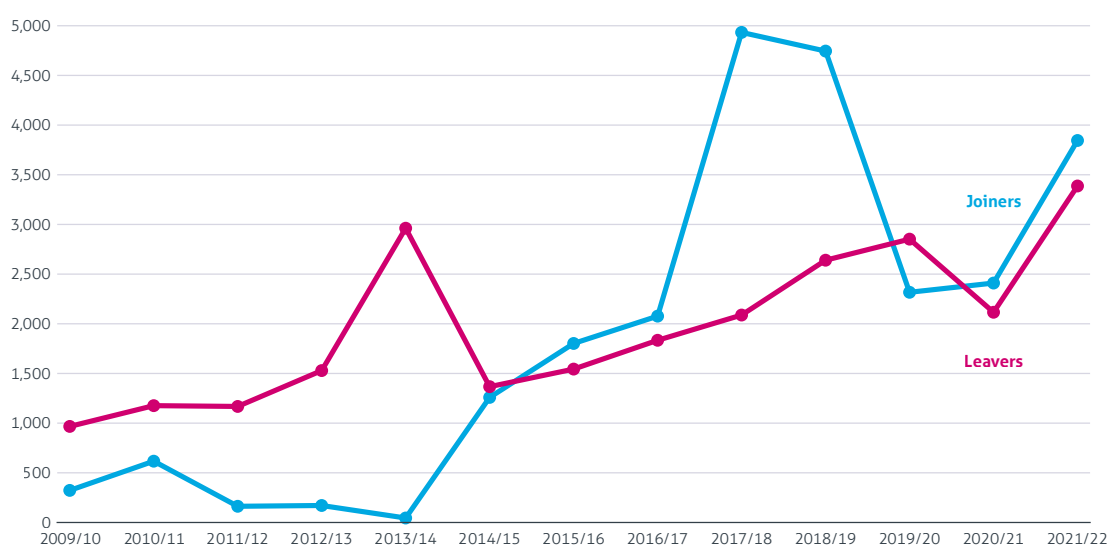
* Spending figures for 2021/22 had not been released at time of publication.

MoJ projects that the prison population will grow dramatically over the coming years, up to 97,500 in 2025,⁶ primarily as a consequence of the government’s policy to increase the number of police officers by 20,000. However, as of July 2022 the prison population was almost 4,000 lower⁷ than the government anticipated when these projections were published in September 2021, again due to delays in the courts.

Staff numbers rose due to higher recruitment – but retention worsened

The number of prison officers increased slightly during 2021/22, having remained flat during the first 12 months of the pandemic. But retention worsened substantially, with 3,387 officers leaving in 2021/22, compared to 2,116 in 2020/21. This was more than offset by the recruitment of 3,845 staff, an increase of 1,435 compared to the year before.⁸ Interviewees noted the success of recruitment campaigns but added that it was increasingly hard to retain staff due to better pay and conditions elsewhere, including other parts of the public sector, particularly the police.

Figure 9.3 **Band 3–5 prison officer joiners and leavers, 2009/10–2021/22**



Source: Institute for Government analysis of HMPPS, ‘Workforce statistics bulletin’, Tables 8a and 8c, 2009/10–2021/22, supported by CIPFA.

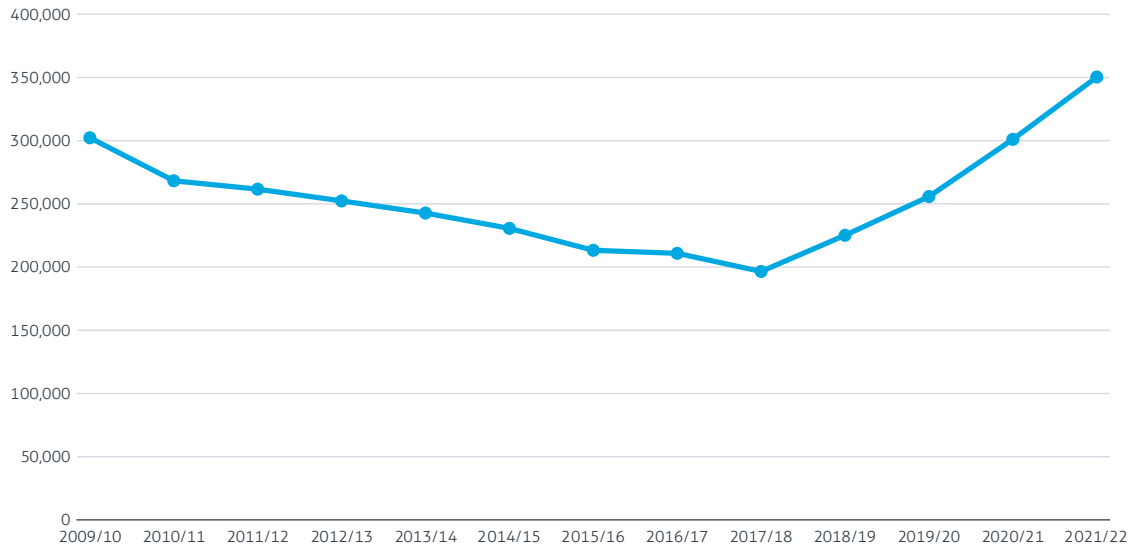
The workforce is insufficient to safely lift restrictions in all prisons

Lockdown regimes were eased from summer 2021 but prisons were required by MoJ to reimplement Covid measures in January 2022 to contain the Omicron wave. Since 9 May 2022, prison governors have had freedom to lift all restrictions.

However, prison regimes vary substantially across the country, even between prisons of the same category.⁹ We were told by interviewees that some prisons still do not have enough staff to safely return prisons to pre-pandemic regimes and that in some only half of a prison wing were allowed out of their cells at any one time. HMIP found that “many prisoners were still locked up for almost 22 hours a day”, even as restrictions in prisons were lifted.¹⁰

The situation has been exacerbated by high levels of staff sickness. In 2021/22, more than 350,000 days were lost to sickness, 21% higher than in 2020/21 and 43% more than 2019/20. Covid-related absences still accounted for more than 20% of the total in 2021/22, with a further 10% due to other respiratory illnesses.¹¹

Figure 9.4 **Band 3–5 prison officer sick days, 2009/10–2021/22**



Source: Institute for Government analysis of HMPPS, 'Workforce statistics bulletin', Table 20, 2009/10–2021/22, supported by CIPFA.

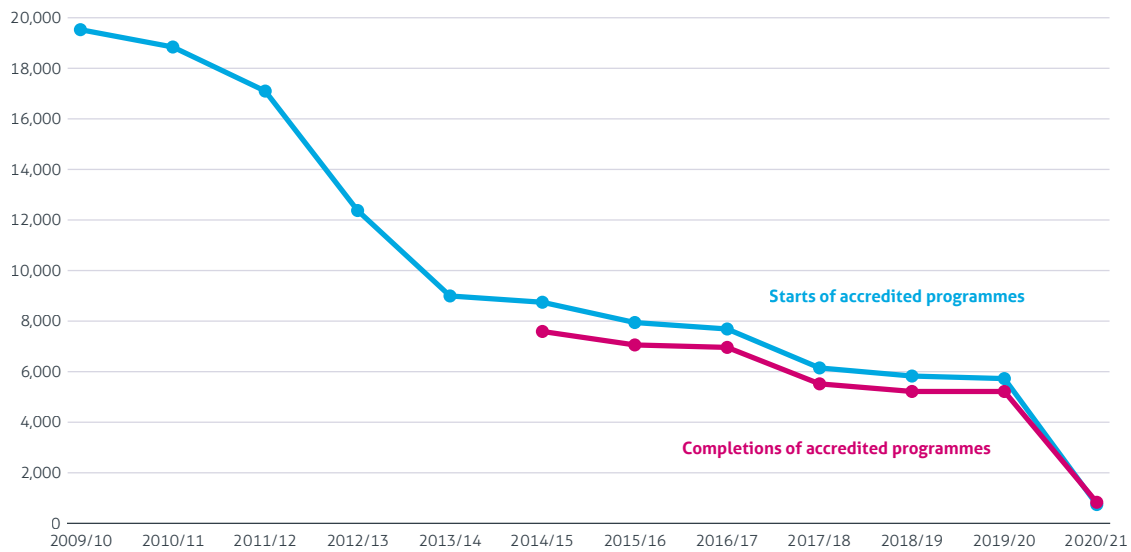
As a consequence of the high staff turnover noted above, the prison workforce is also relatively inexperienced, with more than a fifth of prison officers having been in post for less than two years.¹² Newer staff are less likely to have the trust of prisoners or interpersonal skills that more seasoned officers have, and will tend to be less effective at de-escalating potentially violent situations – something that also has implications for how safely prisons can accommodate the expected rise in the prisoner population.

Continued lockdowns in prisons have reduced access to purposeful activities

Enhanced lockdown regimes in prisons meant that fewer prisoners have been able to access purposeful activities. Inspections by HMIP and Ofsted found that education was badly disrupted with, for example, reading mentors unable to leave their cells to provide sessions to fellow prisoners.¹³

There was a big reduction in both starts and completions of accredited programmes in 2020/21. Just 744 accredited programmes were started, down from 5,726 in 2019/20, a fall of 87%,¹⁴ with completions following a similar trajectory. Interviewees told us that the prison education service has also found it difficult to recruit and retain staff.

Figure 9.5 **Starts and completions of accredited programmes, 2009/10–2020/21**



Source: Institute for Government analysis of HMPPS, 'Offender Equalities Annual Report', Tables 5.2 and 5.9, 2009/10–2020/21, supported by CIPFA. Notes: Accredited programmes are evidence-based treatment programmes covering domestic violence, extremism, general offending, sexual offending, substance misuse and violence.

Prisoners have also been able to work less during the pandemic. The average number of active prisoners* fell by 45% between 2020 and 2021. Work increased substantially in 2022, but there were still 2% fewer active prisoners per month than in 2020.¹⁵

As the access to traditional purposeful activity was limited due to Covid restrictions, prisoners have been given in-cell activity packs and some elements of education courses have been made available to be completed from a cell. However, HMIP's annual report is highly critical of the slow pace at which face-to-face purposeful activity has resumed, blaming a lack of ambition from some governors and the prison service, as well as the reluctance of some providers to come back into prisons.¹⁶

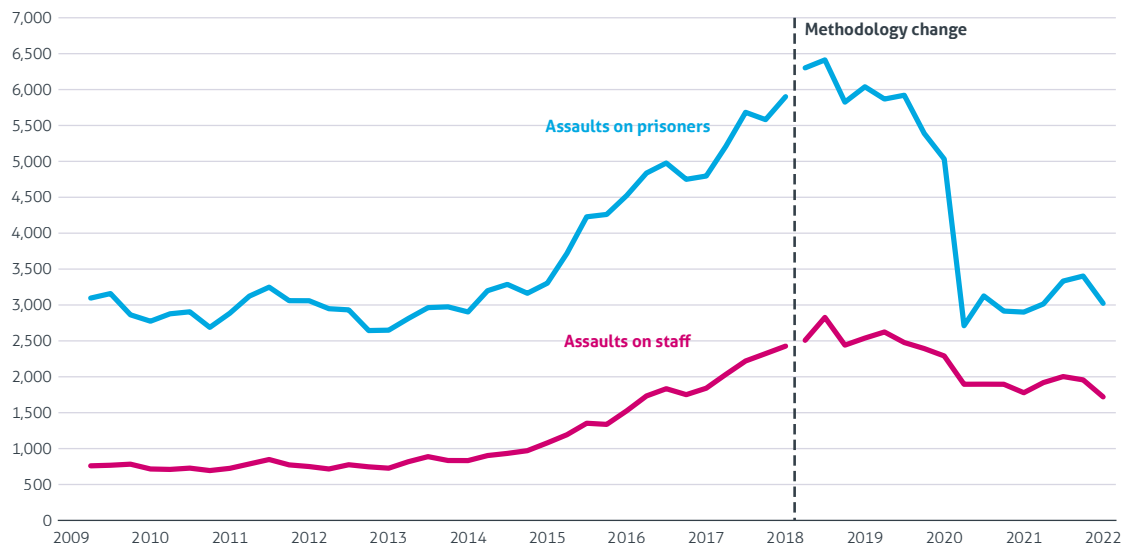
Violence has increased as prison lockdown regimes have been eased

Violence in prisons rose substantially after 2014/15 but had started to fall before the onset of the pandemic, thanks to a wide-ranging safety programme.¹⁷ It then fell dramatically following the introduction of lockdown regimes at the start of the pandemic – unsurprisingly, with prisoners separated for long periods. But incidents of assault rose again as prisons lifted restrictions and face-to-face contact between prisoners, and between prisoners and staff, increased. This situation was probably exacerbated by the noted inexperience of staff, as well as other factors such as “paying off of debts” and frustration at prolonged restrictions.¹⁸

The rate of prisoner-on-prisoner assaults per 1,000 prisoners increased by 16% in 2021/22. However, the rate remains 35% below pre-pandemic levels. The rate of assaults on staff has followed a similar pattern, increasing by 9% in 2021/22.

* The number of prisoners who received a salary.

Figure 9.6 Prison assaults, Q2 2009 to Q1 2022

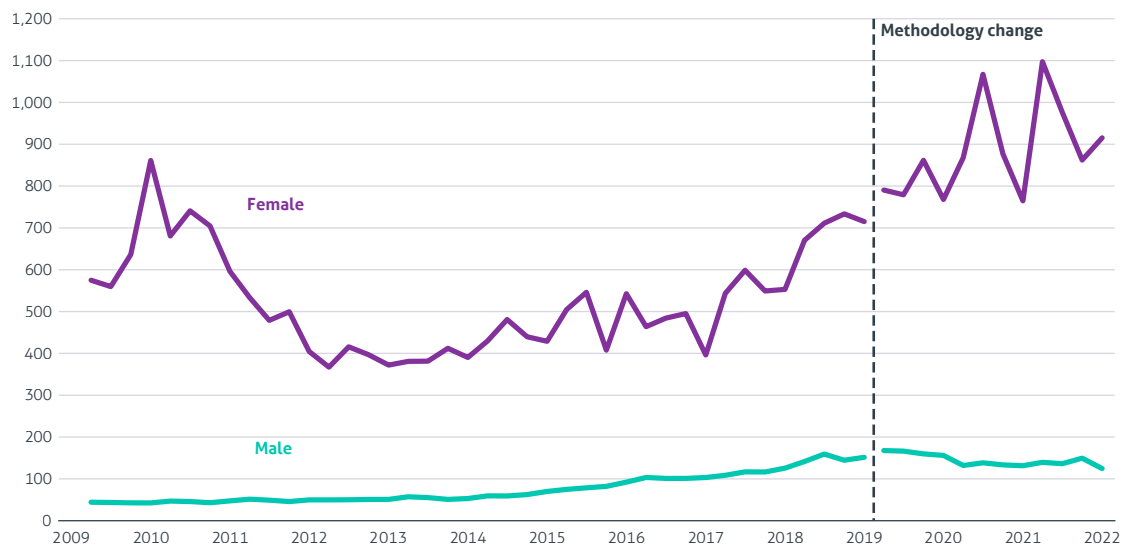


Source: Institute for Government analysis of MoJ, 'Safety in custody statistics', Table 7, Q2 2009–Q1 2022, supported by CIPFA. Notes: Figures from Q2 2018 onwards exclude incidents occurring within the youth estate.

Self-harm has fallen in men's prisons but increased in women's prisons

Self-harm has always been more prevalent in female prisons* but the trends have diverged during the pandemic. The rate of self-harm incidents per 1,000 prisoners in male establishments fell by 11% between 2020/21 and 2021/22. The rate rose by 8% in 2021/22 but remained below pre-pandemic levels.

Figure 9.7 Self-harm rates per 1,000 prisoners, Q2 2009 to Q1 2022



Source: Institute for Government analysis of MoJ, 'Safety in custody statistics', Table 6, Q2 2009–Q1 2022, supported by CIPFA. Notes: Figures from Q2 2019 onwards exclude incidents occurring within the youth estate.

* Self-harm in the women's estate is characterised by a small number of women who self-harm multiple times. More than a third of female prisoners self-harm, compared to 15% of male prisoners.

In female prisons, self-harm incidents per 1,000 prisoners grew by 12% in 2020/21 and by a further 7% in 2021/22. The average of almost 11 incidents of self-harm per individual in 2021/22 is the highest on record – and 17% higher than the pre-pandemic rate.¹⁹

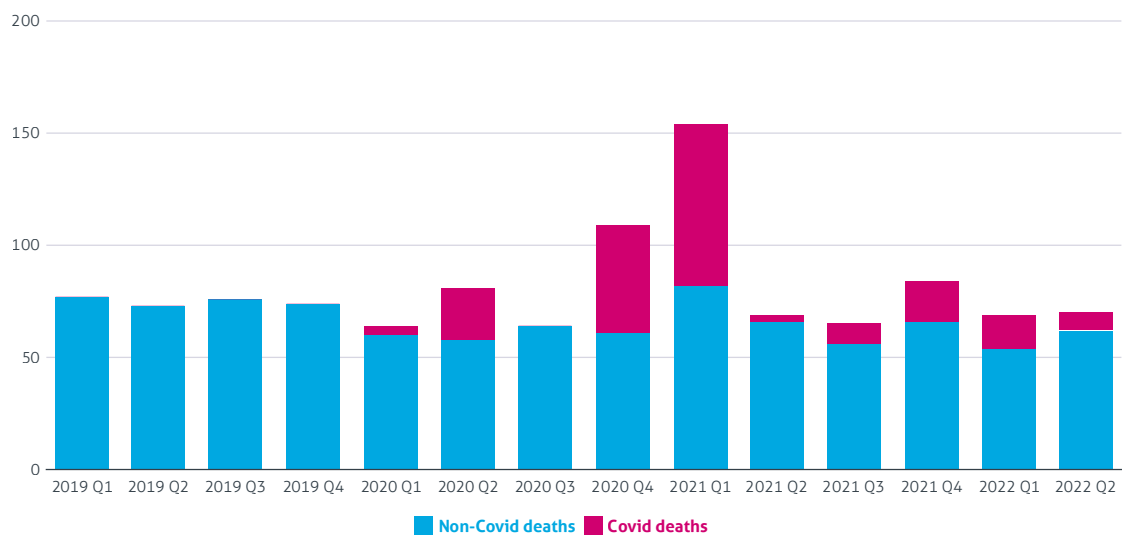
It is unclear what has caused the divergence but HMIP said in its 2020/21 annual report: “Women’s lack of contact with the outside world had led to extreme frustration and many had not seen their children for many months, leaving them feeling lonely and anxious.”²⁰

To address the problem the government works with the Samaritans, and has implemented a new case management approach and training package for staff.²¹

Prisons experienced fewer Covid deaths in 2021/22 than in the first year of the pandemic

In March 2020, Public Health England predicted that as many as 2,700 prisoners could die from Covid.²² However, highly restrictive lockdown regimes within prisons meant that the prison service limited the spread of Covid. There were 200 Covid-related deaths from the start of the pandemic up to the end of June 2022. These peaked over the winter of 2020/21 but have been substantially lower in subsequent waves following the rollout of vaccinations.

Figure 9.8 Deaths in prison, Q1 2019 to Q2 2022



Source: Institute for Government analysis of HMPPS, ‘Covid-19 statistics’, Table 1, March 2020–June 2022; MoJ, ‘Safety in custody statistics’, Table 5, Q1 2019–Q2 2022; supported by CIPFA.

Backlogs have grown and prisoners are waiting longer to access services

There is limited publicly available data on backlogs in prisons. However, according to the MoJ, there are backlogs across its services, including staff training, staff annual leave, offender management assessments, offending behaviour programmes and access to health services.²³ Another interviewee told us that some prisons are keeping prisoners in their cells for even longer than usual one day a week to enable staff to undertake essential training.²⁴

As a result of backlogs and staff shortages, prisoners are waiting for a long time to access a wide range of routine services. Recent inspection reports found prisoners waiting several days before they could call their family after arrival,²⁵ four weeks for GP appointments,²⁶ more than 26 weeks to see an optician,²⁷ and “unacceptable” waits for refunds from prison shops.²⁸ Worryingly, in one establishment, vulnerable prisoners waited several weeks for a bed on a specialist wing and only 19% of prisoners said that emergency cell bells were answered within five minutes.²⁹

The prison maintenance backlog for the highest priority capital works has also grown from £900m in 2019/20 to £1.3bn in 2021/22. These are projects needed to address “significant health & safety and fire safety risks, and/or critical risk to capacity”.³⁰

Methodology

Cross-service analysis

Public services spending, including estimates of the total spend on public services, and Figures 0.2 and 0.3

To estimate the real cost of public spending, we deflate government spending figures using the GDP deflators published in the March 2022 Spring Statement, available at www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2022-spring-statement. 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.

For estimates of historic public spend, we use data from 2009/10 where available, otherwise we draw figures from 2010/11. We draw data from the sources listed in Table 10.1.

Table 10.1 **Data sources for each spending area**

Spending area	Data source
General practice	NHS England, <i>Investment in General Practice in England, 2016/17 to 2020/21</i> , 12 May 2022, retrieved 7 October 2022, www.england.nhs.uk/publication/investment-in-general-practice-in-england-2016-17-to-2020-21
Hospitals	Department of Health and Social Care, <i>Annual Report and Accounts: 2020-2021</i> , The Stationery Office, January 2022, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1052421/dhsc-annual-report-and-accounts-2020-2021-web-accessible..pdf
Adult social care	NHS Digital, <i>Adult Social Care Activity and Finance Report, England - 2020-21</i> , 2021, 'Appendix B: Expenditure on adult social care, 2009-10 to 2020-21', retrieved 7 October 2022, https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2020-21/appendix-b

Children's social care	Department for Education, 'S251 Outturn – Children and Young People's Services (National, Regional, LA levels)', retrieved 7 October 2022, https://explore-education-statistics.service.gov.uk/data-catalogue/la-and-school-expenditure/2020-21 ; DLUHC, 'Local authority revenue expenditure and financing England: 2020 to 2021 individual local authority data – outturn', 2021, retrieved 7 October 2022, www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2020-to-2021-individual-local-authority-data-outturn ; DLUHC, 'Revenue outturn cultural, environmental, regulatory and planning services (RO5) 2020 to 2021', retrieved 7 October 2022, www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2020-to-2021-individual-local-authority-data-outturn ; DLUHC, 'Revenue outturn highways and transport services (RO2) 2020 to 2021', retrieved 7 October 2022, www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2020-to-2021-individual-local-authority-data-outturn
Neighbourhood services	DLUHC, 'Revenue outturn highways and transport services (RO2) 2020 to 2021', retrieved 7 October 2022, www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2020-to-2021-individual-local-authority-data-outturn ; DLUHC, 'Revenue outturn cultural, environmental, regulatory and planning services (RO5) 2020 to 2021', retrieved 7 October 2022, www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2020-to-2021-individual-local-authority-data-outturn
Schools	Department for Education, 'School funding statistics', table 1, retrieved 7 October 2022, https://explore-education-statistics.service.gov.uk/find-statistics/school-funding-statistics/2021-22
Police	DLUHC, 'Revenue outturn central, protective and other services (RO6) 2020 to 2021', retrieved 7 October 2022, www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2020-to-2021-individual-local-authority-data-outturn ; StatsWales, 'Revenue outturn expenditure summary, by service', retrieved 7 October 2022, https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue/Outturn/revenueoutturnexpendituresummary-by-service
Courts	HMCTS, 'Annual report and accounts 2021-22', retrieved 7 October 2022, www.gov.uk/government/collections/hmcts-annual-reports-and-plans
Prisons	HMPPS, 'HMPPS annual report and accounts 2020-2021', retrieved 7 October 2022, www.gov.uk/government/publications/hmpps-annual-report-and-accounts-2020-21

At the time of publication, figures for 2021/22 are not publicly available for all public services. Where this occurs we generate estimates in the following way:

- We impute police spending figures for 2021/22 in England and Wales by estimating the ratio of spend between the 2020/21 budget and actual spend, and then applying this to the budget for 2021/22. We generate figures for 2020/21 by

combining Department for Levelling Up, Housing and Communities (DLUHC) 'Local authority revenue expenditure and financing England: 2020 to 2021 individual local authority data – outturn', 'Revenue outturn central, protective and other services' (RO6 tables for England)¹ and StatsWales 'Revenue outturn expenditure summary, by service' figures for Wales.² We take budget figures for England 2020/21 from Ministry of Housing, Communities and Local Government (MHCLG), 'Local Authority Revenue Expenditure and Financing Budget 2020-21, England' (Table 1)³ and we take figures for 2021/22 from MHCLG, 'Local Authority Revenue Expenditure and Financing Budget 2020-21, England' (Table 1).⁴ Figures for Wales for both years are taken from StatsWales, 'Police authority budget requirement by police'.⁵

- A similar approach is used for the estimates of children's social care, adult social care and neighbourhood services. The data sources and approach are discussed in greater detail in the rest of this chapter.
- Courts figures are taken from HM Courts and Tribunals Service, *Annual Report and Accounts 2021–22, 2022*, and refer to gross spend.⁶
- Prison spending figures for 2021/22 are imputed by assuming that spending on prisons changes in line with the HM Prison and Probation Service (HMPPS) programme budget (Resource DEL, minus administration costs) reported in the 2020/21 annual accounts and HM Treasury's 2021/22 supplementary estimates. See: Ministry of Justice, *Annual Report and Accounts 2020-21* (HC 788), The Stationery Office, December 2021, p. 217; and HM Treasury, *Central Government Supply Estimates 2021-22: Supplementary estimates* (HC 1152), The Stationery Office, February 2022, p. 151.
- Hospital spending figures are imputed by estimating the ratio of planned 2020/21 net spending on NHS providers against 2021/22 supplementary estimate spending plans to establish the uplift in planned spending. This is applied to the estimate for 2020/21 gross expenditure figures to arrive at an estimate for 2021/22. Figures for planned 2020/21 net expenditure come from Department of Health and Social Care (DHSC), *Annual Report and Accounts 2020-21* (HC 1053), The Stationery Office, 31 January 2022, p. 172, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1052421/dhsc-annual-report-and-accounts-2020-2021-web-accessible..pdf. The figure for 2021/22 spending plans comes from DHSC, *Estimates Memorandum: Department of Health and Social Care 2021-22 supplementary estimate*, Parliament.UK, (no date), retrieved 7 October 2022, p. 14, <https://committees.parliament.uk/publications/9044/documents/159167/default>. The figure for 2020/21 gross expenditure comes from DHSC, *Annual Report and Accounts 2020-21* (HC 1053), The Stationery Office, 31 January 2022, p. 239, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1052421/dhsc-annual-report-and-accounts-2020-2021-web-accessible..pdf. These figures include Covid spending.

- A similar approach is followed for general practice. The figure for 2020/21 spending comes from NHS England, *Investment in General Practice in England, 2016/17 to 2020/21*, 12 May 2022, retrieved 7 October 2022, www.england.nhs.uk/publication/investment-in-general-practice-in-england-2016-17-to-2020-21. This figure includes Covid spending. The figure for 2021/22 is calculated by applying the uplift from the combined increase in the budget for 'NHS commissioning boards', 'NHS Provider' and 'NHS Commissioning Board (known as NHS England) net expenditure financed from National Insurance contributions' in the "Supplementary estimates" (see hospitals section above) to the 2020/21 Investment in General Practice figure.
- School spending figures cover both mainstream and non-mainstream schools and relate to funding rather than spending. Figures are derived from published Department for Education (DfE) figures: DfE, 'School funding statistics: financial year 2021-22', GOV.UK, January 2022, retrieved 7 October 2022, <https://explore-education-statistics.service.gov.uk/find-statistics/school-funding-statistics>, with separate Covid funding added to them drawn from figures from the 2022 Spring Statement, available at: HM Treasury, *Spring Statement 2022*, CP 653, The Stationery Office, 2022 (specifically, table 1.6). Figure 2 uses actual figures for 2020/21 which draw from Department for Education, *Consolidated Annual Report and Accounts: For the year ended 31 March 2021* (HC 907), The Stationery Office, 16 December 2021, p.213 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1041620/CCS0121879180-001_DFE_Annual_Report_20-21_Web-Accessible.pdf

Change in demand for public services since 2019/20, actual and projected (Figure 0.4)

For police and neighbourhood services, our assumption is that underlying demand will rise in line with England's population growth. The methodology below describes how we project underlying demand for general practice, hospitals, adult social care, children's social care, schools, criminal courts and prisons, and how we calculate backlogs in criminal courts.

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 2021,⁷ 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 2021.⁸ 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 latest projections for the NLW were published in March 2022.⁹ But since then, expectations over increases in nominal wages have increased. As the target is for the NLW to equal two thirds of median wages by 2025, this also increases the projected path of the NLW. As a result, we scale up the March estimates in line with the change in the Bank of England's forecast for average weekly earnings between its February 2022¹⁰ and August 2022¹¹ forecasts. To calculate the impact of a higher NLW on adult social care local authority budgets, we use the Institute for Fiscal Studies' assumption that every 1% increase in the NLW costs 50£m.¹² In total, we calculate that above-inflation increases in the NLW will cost local authorities an additional 650£m in 2024/25 over 2021/22. To ensure consistency with other services, we do not incorporate these cost pressures into Figure 0.4 (which looks only at projected increases in demand), but we do include them in Figure 0.5 (which compares the generosity of the spending review settlement to increases in ongoing demand).

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. For each category, we make the assumptions about rates of growth set out in Table 10.2.

Table 10.2 **Projected growth rates for children's social care**

Service category	Gross spending 2019/20 (£bn)	Growth rate assumption	Projected growth 2019/20 to 2024/25
Foster placements	£1.8bn	Increases in line with the growth in the rate of foster placements per child between 2007/08 and 2019/20	9.7%
Residential care	£1.6bn	Increases in line with the growth in the rate of residential care placements for children in England between 2007/08 and 2019/20	6.7%
Other expenditure	£5.8bn	Increases in line with the rate of episodes of need per child in England between 2012/13 and 2019/20	8.6%

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 2018.¹³ 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.¹⁴ 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, with the government planning to increase officer numbers by 20,000 on top of 2018/19 figures by April 2023.¹⁵ 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 the number of charges per officer will return to and stay at 2019/20 levels, though this is uncertain. For simplicity, we assume that the additional officers are present throughout the year, and so they have a constant impact on charging from April to March.

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. All other cases, in both the crown and magistrates' courts, increase in line with police charges.

Prisons

To project demand for prisons, we use the Ministry of Justice's (MoJ) central estimate for prisoner numbers over the five years from 2021 to 2026, which was published in November 2021.¹⁶

The MoJ's central estimate is that the prisoner population will rise by 15.7% between 2019/20 and 2024/25 (and by 23% between 2020/21 and 2024/25). 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.

The projections are contingent on assumptions about the number of cases processed in the courts and do not factor in the impact of the barristers' strike. At the time of writing, actual prisoner numbers were lower than the November 2021 projections implied.

Cost of 2022/23 public sector pay awards (Table 2)

To calculate the cost of public sector pay increases, we multiply staff costs by the average increases in pay awarded for 2022/23, most of which were published in summer 2022 but backdated to April. We take the share of spending on staff in 2019/20 to ensure that temporary pandemic effects do not skew our findings.

For each of our nine services, we calculate the cost of 2022/23 public sector pay awards relative to a 2.5% increase, because in spending review 2021 the assumption was a 2–3% increase. We also calculate the additional cost of increasing pay in line with private sector wages (5.25% in the Bank of England's August 2022 forecast).¹⁷

This is an underestimate of the total cost of increased wages in public services, because wage costs in the private sector will indirectly increase public service costs. One example is adult social care, where the public sector procures many services from the private sector and only provides a minority of social care directly.

Hospitals

We calculate the effect of the pay award on hospital spending as the average of costs in relation to doctors and other staff (4.5% and 4.75% respectively).¹⁸

Staff costs are taken from the DHSC annual report and accounts, showing that 64% of hospital spending is staff costs.¹⁹

GPs

Only salaried GPs and other GP staff are covered by pay review body recommendations (where awards are the same as for hospital doctors). Partner GPs are not paid a direct salary, but rather take their income as the overall profit from the practice.

We calculate the share of total GP spending on salaries covered by pay review bodies using data on the number of salaried GPs, partner GPs and other staff from NHS Digital,²⁰ data on the salaries of salaried GPs and the incomes of partners from another NHS Digital dataset²¹ and an assumption from the Health Foundation's REAL Centre that 73% of total costs in primary care are staff costs.²²

We assume that the average salary for a non-GP employee in a practice is 30,000£ a year, close to the UK full-time average salary. Based on the reported numbers of salaried and partner GPs and other staff and reported spending, we calculate that the income of partners accounts for 38.5% of staff costs in GP practices. This implies that 45% of total spending on GPs (61.5% of the 73% of total spending accounted for by pay costs) is covered by pay review bodies.

Adult social care

We take reported spending on staff costs for adult social care from local authority returns.²³ This only accounts for direct spending on staff, and implies that only 15% of adult social care spending is direct spending on staff covered by the National Joint Council for Local Government Services (the equivalent of a pay review body in that sector). The award this year was a flat 1,925£ increase for every worker, which equates to around a 5% pay bill increase.²⁴

Children's social care

We take reported spending on staff costs for children's social care from local authority returns.²⁵ This only accounts for direct spending on staff, and implies that only 34% of children's social care spending is direct spending on staff covered by the National Joint Council for Local Government Services. The award this year was a flat 1,925£ increase for every worker, which equates to around a 5% pay bill increase.²⁶

Neighbourhood services

We take reported spending on staff costs for neighbourhood services from local authority returns.^{27,28} This only accounts for direct spending on staff, and implies that only 19% of neighbourhood services spending is direct spending on staff covered by the National Joint Council for Local Government Services. The award this year was a flat 1,925£ increase for every worker, which equates to around a 5% pay bill increase.²⁹

Schools

Unlike other services, schools' pay awards cover school years (September to August) rather than financial years. For fair comparison, we look at the cost increase for the full 2022–23 school year.

On average, the award for 2022–23 equates to a 5.4% increase in school pay bills.³⁰ We take spending on staff from the DfE's technical note on the composition of school costs, which shows that 80% of schools' spending is on staff.³¹

Police

The police pay award amounts to a 5% increase in pay bills on average.³² Spending on staff accounts for 78% of police spending, based on DLUHC, 'Local authority revenue expenditure and financing England: 2020 to 2021 individual local authority data – outturn'³³ and StatsWales, 'Revenue outturn expenditure summary, by service' figures for Wales.³⁴

Criminal courts

Pay awards in the courts system cover two different types of employee. Court staff account for 28% of total HM Courts and Tribunals Service (HMCTS) spending,³⁵ and are covered by a three-year pay deal that predates the Covid crisis and gives a 2.8% award for 2022/23.³⁶ Expenditure on judges accounts for 29% of HMCTS expenditure,³⁷ with a judge pay award of 3% in 2022/23.³⁸

Prisons

The Prison Service Pay Review Body estimated that its recommendations, which included basic pay increases and higher allowances, would lead to an 8.5% increase in prison pay bills.³⁹ Spending on staff accounts for 41% of total spending on prisons.⁴⁰

Difference between the average annual real-terms increase in services' budgets and the projected increase in demand between 2021/22 and 2024/25 under different inflation scenarios (Figure 0.5)

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 GPs and 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).

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 and then the GDP deflator at the Spring Statement in March 2022, both from the Office for Budget Responsibility (OBR). More recent projections are more difficult to come by because the GDP deflator is not something that most forecasters project. But the June 2022 World Economic Outlook from the Organisation for Economic Co-operation and Development (OECD) does include a projection that factors in more recent inflation expectations and so we take its projections for 2022 and 2023 from there and assume 2024 increases are the same as in the 2022 Spring Statement.

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 2021/22 spending on each service.

Average change in justice sector waiting times since 2019/20 (Figure 0.6)

'Offence to charge', 'Charge to first listing', and 'First listing to completion dates' waiting times (in days) are taken from MoJ, '[Criminal court statistics quarterly: April to June 2022](#)', table T4, columns F, H and T, retrieved 7 October 2022, www.gov.uk/government/statistics/criminal-court-statistics-quarterly-april-to-june-2022.

Percentage change in backlogs in elective care and the crown courts (Figure 0.7)

For the percentage change in backlogs in elective care and the crown courts we looked at, respectively: NHS England, '[Consultant-led Referral to Treatment Waiting Times Data 2021-22](#)', RTT Overview Time series, March 2022, retrieved 7 October 2022, www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22; and HMCTS, '[Criminal court statistics quarterly, January to March 2022](#)', retrieved 7 October 2022, www.gov.uk/government/statistics/criminal-court-statistics-quarterly-january-to-march-2022, Table C1.

The hospitals and courts data is recorded over different time periods, with hospitals data recorded on a monthly basis at the start of the month and criminal courts data recorded on a quarterly basis on the last day of the reporting quarter. To ensure greater consistency across data series, we have selected the closest hospital date to the respective reporting quarter, that is, data from 1 April 2022 for hospitals is reported alongside Q4 2021/22 courts data.

Forecast impact of police uplift on total charges (Figure 0.9)

The charge rate per officer is generated using officer numbers data available from Home Office, 'Police workforce England and Wales statistics', retrieved 7 October 2022, www.gov.uk/government/collections/police-workforce-england-and-wales and charge/summonsed data is from Home Office, 'Crime outcomes in England and Wales 2021 to 2022', retrieved 7 October 2022, www.gov.uk/government/statistics/crime-outcomes-in-england-and-wales-2021-to-2022/crime-outcomes-in-england-and-wales-2021-to-2022#further-information.

The 2019/20 charge rate per officer is used to generate forecast charged/summons by multiplying against the March 2023 total police officer recruitment target. The target was taken from Home Office, 'Police officer uplift, quarterly update to June 2022', retrieved 7 October 2022, www.gov.uk/government/statistics/police-officer-uplift-quarterly-update-to-june-2022/police-officer-uplift-quarterly-update-to-june-2022.

The recruitment target has changed since the initial announcement following revisions to the October 2019 baseline – discussed in further detail at Home Office, 'Police officer uplift, quarterly update to June 2022', retrieved 7 October 2022, www.gov.uk/government/statistics/police-officer-uplift-quarterly-update-to-june-2022/police-officer-uplift-quarterly-update-to-june-2022. Figures for 2023/24 and 2024/25 have duplicated this figure on the basis that there is no current evidence of any additional uplift in police officers after this period, and there is no evidence to suggest a clear alternative trend to the charge rate. This is therefore an inexact forecast for total charges.

1. General practice

Appointments in general practice (Figure 1.4)

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. There is, however, a consistent time series of the number of referrals that GPs have made that is available back to 2008.

Referrals (Figures 1.6 and 1.7)

Spending on GP services comes from the 'Investment in General Practice in England, 2016/17 to 2020/21' dataset.⁴¹ For 2020/21, this dataset splits out the amount that the NHS provided GPs for spending on Covid-related activity. This information allows us to plot a separate data point for Covid spending in 2020/21.

We start the referral rate time series from the point when there is consistent appointments data, as specified above. For the referral rate, we calculate the proportion of attended appointments that GPs conducted that resulted in a specific and acute GP referral. 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

Number of direct patient care staff employed in primary care (Figure 1.9)

For the projected number of direct patient care (DPC) staff, we calculate the number of DPC staff that the NHS has added to the service per quarter since March 2019. We then extrapolate that forward, to come to a total number of DPC employees if recruitment continues at its current pace.

Size of job groups within the primary care workforce (FTE) (Figure 1.10)

The number of GPs used in this chart is the 'All regular GPs (excludes locums)' line from the GP Workforce bulletin tables. This is a combination of 'All qualified permanent GPs' and 'GPs in training grades' from the same dataset.

Percentage change in the number of patients registered with GP practices and the number of GPs, since September 2015 (Figure 1.11)

As with Figure 1.10, the change in the number of GPs refers to the percentage change in the number of 'All regular GPs (excludes 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.

2. Hospitals

Beds per head (Figure 2.6)

For this chart, we take the total number of general and acute overnight beds from NHS England's 'Bed availability and occupancy' dataset and divide this number by the number of people in England in the relevant year from the Office for National Statistics (ONS) 'Mid-year population estimate' dataset.

Staffing (Figure 2.7)

Nursing numbers include adult and children's nurses who work in hospitals, but do not include community nurses from the 'NHS workforce statistics' dataset.

Doctor numbers are taken from the 'NHS workforce statistics, doctors by grade and speciality' dataset. The total number of doctors includes consultants, associate specialists, specialty doctors, staff grade doctors, specialty registrars, F1 and F2 doctors and hospital practitioners/clinical assistants.

Voluntary resignations (Figure 2.9)

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.

Staff absences (Figure 2.10)

NHS England has 25 categories for staff absences, but no specific number for absences due to Covid. We produced an upper-bound estimate for this number by combining the total number of absences listed under S13 Cold cough flu – influenza, S15 Chest & respiratory problems and S27 Infectious diseases. But in practice this will have caught a proportion of non-Covid absences. Our upper-bound estimate of mental health absences uses the numbers reported under S10 Anxiety/stress/depression/other psychiatric illnesses. We cannot preclude the possibility that some staff absences for either Covid or mental health were reported under S98 Other known causes – not elsewhere classified, or S99 Unknown causes/not specified, but for the sake of simplicity we disregarded this.

In all cases we calculate the number of full-time equivalent (FTE) days lost to sickness in a given month for each category as a share of the total FTE days available, and present this percentage as the sickness absence rate.

3. Adult social care

Covid-related spending on adult social care in 2020/21 and 2021/22 (Figure 3.1)

This information comes from the 'Covid-19 financial impact monitoring information' dataset, released in 20 rounds by DLUHC. Quarterly totals are calculated by summing monthly totals where this is relevant. Spending details for some months are not

available in the dataset and in these instances we impute those monthly amounts through comparisons between year-to-date (YTD) amounts in different releases. For example, Round 17 does not include a monthly amount for October 2021, and only shows the financial YTD total for April to October 2021. But Round 16 includes YTD data to the end of August 2021 and forecasts spend for September 2021. Combining the August YTD actuals with the September forecast means that we could create a YTD September total, which, when subtracted from the YTD October actuals, would give an estimate for the spending in October 2021. This means that the monthly totals are likely to not be completely accurate, as September actuals might have differed from the September forecast. But they are close enough for the imputation to be useful.

It should be noted that it was impossible to impute separate totals for July and August 2021 and November and December 2021 because the survey data was released too infrequently for this to be possible. Instead, we calculate a total for the two months. This should not be a problem as, in both cases, the months fall in the same quarter (Q2 2021/22 and Q3 2021/22 respectively) and therefore are shown in aggregate on the chart.

Change in spending on adult social care in England since 2009/10 (real terms) (Figure 3.2)

The data point for 2020/21 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 – 2020-21' (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 2021/22, we calculate the change in spending between the amount spent on adult social care in 'Revenue outturn social care and public health services (RO3) 2020 to 2021' and the amount that local authorities were forecast to spend on adult social care in 2021/22, as outlined in the 'Revenue account budget 2021 to 2022' document. We then take this percentage change and apply it to the amount spent in 2020/21 from the ASCAFR. While this means that the forecast amount spent in 2021/22 will not be completely accurate, we feel that it is a fair assumption as the amount that local authorities spent on adult social care in 2020/21 (£18.7bn) accounts for approximately 90% of the 20.7£bn spent on adult social care in the ASCAFR dataset.

We calculate the spending – excluding Covid support – data points on the chart by subtracting the additional local authority spending on adult social care (as laid out in Figure 3.1) from the total adult social care spending as described in the paragraph above.

Change in clients per head accessing long-term support during the year since 2014/15, by age band (Figure 3.8)

This is calculated as the number of people accessing long-term care during the year – from SALT table 36, in ASCAFR – divided by the number of people in the country in that year, as laid out in the ONS's mid-year population estimates.

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 2020/21 is the actual spend on children's social care, as outlined in the DfE's 'Local authority and school expenditure 2020 to 2021' 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 2021/22, 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) 2020 to 2021' and the amount that local authorities were forecast to spend on children's social care in 2021/22, as outlined in the 'Revenue account budget 2021 to 2022' document. We then take this percentage change and apply it to the amount spent in 2020/21 from the DfE figures. While this means that the forecast amount spent in 2021/22 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 2020/21 (£9.1bn) accounts for approximately 93% of the £9.8bn spent on children's social care in the DfE dataset.

We calculate the spending – excluding Covid support – data points on the chart by subtracting the additional local authority spending on children's social care (as laid out in Figure 4.2) from the total children's social care spending as described in the paragraph above.

Additional pandemic-related children's social care spending, 2020/21–2021/22 (Figure 4.2)

This information comes from the 'Covid-19 financial impact monitoring information' dataset, released in 20 rounds by DLUHC. Quarterly totals are calculated by summing monthly totals where this is relevant. Spending details for some months are not available in the dataset and in these instances we impute those monthly amounts through comparisons between year-to-date (YTD) amounts in different releases. For example, Round 17 does not include a monthly amount for October 2021, and only shows the financial YTD total for April to October 2021. But Round 16 includes YTD data to the end of August 2021 and forecasts spend for September 2021. Combining the August YTD actuals with the September forecast means that we could create a YTD September total, which, when subtracted from the YTD October actuals, would give an estimate for the spending in October 2021. This means that the monthly totals are likely to not be completely accurate, as September actuals might have differed from the September forecast, but they are close enough for the imputation to be useful.

It should be noted that it was impossible to impute separate totals for July and August 2021 and November and December 2021 because the survey data was released too infrequently for this to be possible. Instead, we calculate a total for the two months. This should not be a problem as, in both cases, the months fall in the same quarter (Q2 2021/22 and Q3 2021/22 respectively) and therefore are shown in aggregate on the chart.

5. Neighbourhood services

Additional Covid spending on neighbourhood services and other local authority-provided services, Q1 2020/21 to Q4 2021/22 (Figure 5.1)

This information comes from the 'Covid-19 financial impact monitoring information' dataset, released in 20 rounds by DLUHC. Quarterly totals are calculated by summing monthly totals where this is relevant. Spending details for some months are not available in the dataset and in these instances we impute those monthly amounts through comparisons between year-to-date (YTD) amounts in different releases. For example, Round 17 does not include a monthly amount for October 2021, and only shows the financial YTD total for April to October 2021. However, Round 16 includes YTD data to the end of August 2021 and forecasts spend for September 2021. Combining the August YTD actuals with the September forecast means that we could create a YTD September total, which, when subtracted from the YTD October actuals, would give an estimate for the spending in October 2021. This means that the monthly totals are likely to not be completely accurate, as September actuals might have differed from the September forecast, but they are close enough for the imputation to be useful.

It should be noted that it was impossible to impute separate totals for July and August 2021 and November and December 2021 because the survey data was released too infrequently for this to be possible. Instead, we calculate a total for the two months. This should not be a problem as, in both cases, the months fall in the same quarter (Q2 2021/22 and Q3 2021/22 respectively) and therefore are shown in aggregate on the chart.

Neighbourhood services spending here includes all emergency spending on: cultural and related services; housing, environment and regulatory; and planning and development. 'Other local authority spending' is the remainder of local authority emergency Covid support, excluding spending on public health, local authority education support services, 'other – costs associated with foregone savings/delayed projects' and police, fire and rescue services. We exclude these items to make the totals in this chart comparable with other spending amounts in the chapter, where we also exclude public health, education and police, fire and rescue services. We exclude public health because this only became a local authority responsibility in 2013/14 while our time series for neighbourhood services spending extends to 2009/10, meaning that this spending would be incomparable with other spending amounts in the chapter. We exclude education and fire, police, and rescue services because local authorities do not have any control over the level of spending on these services.

Usable reserves as a proportion of total expenditure by type of authority, 2009/10–2022/23 (Figure 5.3)

We calculate usable reserves as the sum of 'Estimated unallocated financial reserves level at 31 March' and 'Estimated other earmarked financial reserves level at 31 March'. Total service expenditure is calculated as the 'Total service expenditure' from the revenue summary minus 'Public health' spending and 'Education services' spending. We conduct this calculation for shire district local authorities and for those local authorities with responsibility for adult social care (which include London boroughs, metropolitan districts, unitary authorities and shire counties). To calculate usable reserves as a percentage of total expenditure, we divide the calculated usable reserves by the total service expenditure.

7. Police

Change in gross police spending since 2009/10 (real terms) (Figure 7.1)

Police spending figures for 2021/22 in England and Wales are imputed by estimating the ratio of spend between the 2020/21 budget and actual spend and then applying this to the budget for 2021/22. Figures for 2020/21 are generated by combining DLUHC 'Local authority revenue expenditure and financing England: 2020 to 2021 individual local authority data – outturn', 'Revenue outturn central, protective and other services' RO6 tables for England⁴³ and StatsWales, 'Revenue outturn expenditure summary, by service' figures for Wales.⁴⁴ Budget figures for England 2020/21 are taken from MHCLG, 'Local Authority Revenue Expenditure and Financing Budget 2020-21, England' Table 1⁴⁵ and figures for 2021/22 are taken from MHCLG, 'Local Authority Revenue Expenditure and Financing Budget 2020-21, England' Table 1.⁴⁶ Figures for Wales for both years are taken from StatsWales, 'Police authority budget requirement by police'.⁴⁷

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, www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/methodologies/userguidetocrimestatisticsforenglandandwales/measuringcrimeduringthecoronaviruscovid19pandemic.

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

Backlog calculations (Figure 8.8)

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

Change in spending on prisons since 2009/10 (real terms)

To project spending in 2021/22, for which the official total is not yet published, we update the 2020/21 spending figure in line with the increase in HMPPS spending between 2020/21 and 2021/22 published in the supplementary estimates laid before parliament in February 2022.⁴⁸

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