CIPFA
The Chartered Institute of Public Finance & Accountancy

INSTITUTE FOR GOVERNMENT

Performance Tracker 2021

Assessing the cost of Covid in public services

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About Performance Tracker

Performance Tracker is an ongoing analysis of the performance of public services. This sixth edition brings together more than 250 indicators to analyse how the coronavirus pandemic affected spending, staff and performance in nine public services – including hospitals, schools and criminal courts.

Produced in partnership by the Institute for Government and the Chartered Institute of Public Finance and Accountancy, the analysis examines changes in working practices in detail and analyses the pandemic's legacy in public services and how much the government would have to spend to return performance – such as NHS waiting lists and court cases waiting to be heard – to pre-pandemic levels.

Find out more:
www.instituteforgovernment.org.uk/performance-tracker

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Forewords

I am delighted to introduce the 2021 edition of *Performance Tracker*. This year's report analyses how the coronavirus pandemic affected public service spending, staff and performance in detail. After an unprecedented year of disruption, it is vital that the government looks at how public services are performing, as well as the money going in.

In this year's edition we have analysed the pandemic's legacy in public services and how much the government would have to spend to return performance – such as NHS waiting lists and court cases waiting to be heard – to pre-pandemic levels. We have examined changes in working practices in detail. Where the government still lacks critical data we have said so, and recommended improvements to enable it to understand and manage public services better.

This report has benefited from many conversations with those involved in public services who have talked to us in great detail. We appreciate their time and thank them.

Bronwen Maddox, Director, Institute for Government

This marks CIPFA and the Institute for Government's sixth iteration of *Performance Tracker*. Analysing the impact of government spending on public service performance is never an easy task, and due to the coronavirus pandemic, this year's report was perhaps our most challenging, but we hope its conclusions are our most insightful yet.

This year's tracker follows a year of intermittent, pandemic-induced funding for public services and an array of policy changes. With the UK economy back open and life returning to some sense of normality, the priority has now shifted towards economic recovery, climate action and addressing regional inequality across the UK through the government's 'levelling up' agenda.

The timing of this *Performance Tracker* is significant. Together with our colleagues at the IfG, we have provided a clear view of the impact the pandemic has had on public services to inform the Treasury's 2021 spending review. The findings are clear: backlogs are at record highs across public services in England, and the cost of providing essential services is expected to increase. The current path we're on is not sustainable.

The challenges experienced by public service providers are continually evolving, and what is most needed is certainty. All eyes will be on the government's recovery plan and how it responds to the current backlog crisis we find ourselves in. We hope this report and its recommendations provide evidence-based guidance to make its response as targeted and impactful as possible.

Rob Whiteman, Chief Executive, CIPFA

Summary

The Conservative government was elected on a clear pledge about public services: it would increase spending, with particularly large increases for the NHS, schools and the police, as much as anything to boost staff numbers. But the pandemic threw those plans into disarray and forced the government to pump huge sums of extra money – £155 billion in 2020/21 and 2021/22 – into public services. As of May 2021, £46.1bn had been spent on the nine public services in England that we cover in this report.[*]

For some services such as schools and local authorities this extra funding was not enough to meet the increased demands Covid placed on key services. There are huge backlogs building up in elective care, criminal court cases, referrals to children's social care and school learning. The cost of extra Covid spending, combined with the money already allocated to the NHS, social care, schools, defence and overseas aid, means the chancellor has little room for manoeuvre in October's multi-year spending review. While Rishi Sunak has already allocated extra money to the NHS to tackle backlogs that have built up over the past 18 months through the new health and social care levy, a key question for government is whether to tackle all backlogs now with extra funding or risk pushing up costs in the future.

In this year's edition of *Performance Tracker*, we assess 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 coronavirus and what the outlook is for the rest of this parliament. For each we have analysed how much was spent during the pandemic; what those services delivered, and how their ways of working changed; and how staff have been affected, and what demands they are likely to face over the next few years from existing pressures and from the legacy of Covid.

The crisis prompted rapid change in the way many services were delivered; technological transformations that might have taken years in normal times happened almost overnight. Some of these have proved to be highly effective; others have resulted in poorer service outcomes and should not be continued. Some of the new demands and problems in delivering services created by Covid are likely to last for some time.

[*] We calculate this by recategorising Covid support schemes reported in the National Audit Office Covid cost tracker according to the nine public services we cover. We include Test and Trace and vaccines. See National Audit Office, 'COVID-19 cost tracker', (no date), retrieved 13 October 2021, www.nao.org.uk/covid-19/cost-tracker. Full methodology available on request.

The chancellor will announce the results of the government's spending review on 27 October. This will set out plans for spending on public services beyond March 2022. In making these plans, the government will have to decide how to prioritise public funds:

- Is more money needed overall for public services than was expected before the pandemic?
- Are some services now judged to be higher priority than they were before Covid?
- Does the government think all the pledges it made before the crisis are still the top priorities?

In early September, the government allocated extra money to the NHS to tackle backlogs that have built up over the past 18 months and to expand eligibility for, and cap the costs of, publicly funded social care. But it is not only the NHS that faces such backlogs, and the government risks pushing up costs later if backlogs elsewhere in the UK's public services are not addressed. The spending review should also consider how services can embed changes in the use of technology and new ways of working that have proved valuable during the pandemic, but which might require upfront funding to continue.

This spending review will entail some very difficult decisions for the government. It must strike the right balance between funding for public services, the level of taxation and public borrowing – all amid continued uncertainty about the longer-term impact of Covid and Brexit on the UK's growth prospects. The analysis in this report sets out our analysis of the choices facing the government, particularly of where there is greatest need for spending to maintain standards and opportunities for change.

What is Covid's legacy for public services?

Backlogs have built up in many services

None of the services we examine has been able to operate as before during the pandemic. Upheaval in health services and schools was obvious but there was also less visible disruption in other services – such as prisons, where most rehabilitative activity, including education and offender behaviour programmes, was halted for long periods, to the detriment of prisoner wellbeing.

For at least five of the nine services – hospitals, general practice, criminal courts, schools and children's social care – the pandemic has led to quantifiable backlogs. Waiting lists for elective operations are now longer than at any point since at least 2007. Criminal courts heard fewer cases than normal: 40% of crown court cases had been waiting for more than six months at the end of March 2021, compared to just 25% at the end of December 2019. Children's social services received 11% fewer referrals between April 2020 and July 2021, despite many children living in riskier environments. Local authorities were unable to identify, assess and support children as quickly or effectively as they ordinarily would.

Most children missed out on almost half a school year's worth of in-person teaching and will need extra help to catch up. Adults who received less or no publicly funded care during the pandemic may have seen their health deteriorate to an extent where they will now require more care support.

Work has begun to tackle these backlogs but more will be needed over the next few years to return them to pre-pandemic levels. For some services – such as hospitals, general practice and criminal courts – shortages of trained staff and facilities will limit the speed at which the backlogs can be reduced, even if extra money were made available. The public sector could increase capacity in some areas by buying in services from the private sector, but not all of this capacity is genuinely additional. Many staff in private hospitals already work in both private health care and the NHS, for example.

Covid has created new demands

Health services in particular will experience continued high demand as a result of coronavirus. Covid will continue to be endemic in the UK, meaning hospitals and GPs will have to continue treating a steady stream of affected patients, even if lower than during the worst of the crisis. Long Covid, still lacking formal medical definition, will expand the number of people requiring management of a chronic disease. It is likely that health services will need to deliver an annual Covid vaccination programme.

Services will cost more to run

Even though the scale of the threat from Covid has started to wane, it will have ongoing consequences for how health and care services operate. The NHS and social care will face higher costs for some time to come as they will need to retain more stringent infection control measures, at least over the next few months given the risk of new variants. Hospitals may have to operate with fewer beds to allow for greater spacing on wards and retain more time-consuming cleaning regimes between patients, for example. Local authority directors also expect that adult social care providers will have to maintain more rigorous infection control measures in 2021/22.

The pandemic has also illustrated the risks of running public services with little spare capacity. If the government wanted to respond to calls for services to be made more resilient than they were before the pandemic, this would require higher recurrent spending to expand service capacity.

Covid has prompted new ways of working and use of new technologies – some of which have improved service efficiency and quality

Many public services adapted rapidly in how they delivered services when the pandemic hit. GPs started to conduct most consultations by telephone, schools rolled out remote learning, courts started to hold more hearings by video link, the police took witness statements over the telephone rather than in person, prisons installed telephones in some cells and introduced video-calling facilities, and children's social workers started to use video calls to stay in touch with children and families.

Some of these were changes services had been intending to make for many years but which had been slow to catch on, or that had been in trial and brought forward – such as greater use of technology in courts, more GP phone consultations and in-cell telephones in prisons. These can be seen as rare positives to take from the crisis, shaking up entrenched behaviours to deliver perceivable benefits – both for service users and providers. More people can get a GP appointment quickly if they are done by telephone, and the rate of non-attendance of telephone appointments is far lower – meaning less of GPs' time is wasted. For routine court hearings, where little interaction is required between the participants, lawyers report that remote hearings are more efficient and just as effective as in-person. Installing telephones in prisoners' cells and giving them access to video calls with family appears to have had positive effects on prisoners' mental health, their introduction coinciding with a marked drop-off in prisoner violence and self-harm.

These positive changes should be retained and service providers should work to ensure that the full potential benefits are realised – for example, changing how staff time is allocated and how buildings are laid out to better suit these new ways of working.

However, other changes – while essential during the pandemic – were less effective and should not be continued. While a minority of children appear to have benefited from remote teaching, overall the evidence is that children missed out on learning and that time away from the classroom exacerbated existing inequalities in outcomes. Children from more disadvantaged backgrounds had greater difficulty accessing resources and engaging actively with learning during the lockdowns, resulting in larger falls in their performance.

Similarly, while violence declined dramatically in most prisons due to the stringent lockdown regimes, being locked up for 23 hours a day curtailed prisoners' ability to participate in meaningful activity and pursue rehabilitation, and has had severe effects on mental health. And again, while some positives can be seen in children's social care, almost all parents said remote child protection conferences and court hearings were much worse than in-person equivalents.

Recruitment and retention problems eased during the pandemic, but this will not last

The poor state of the private sector labour market during the pandemic contributed to a fall in the number of people leaving public sector jobs (and jobs at private or charitable public service providers), accompanied by a rise in applications. This was despite a reduction in availability of EU workers, who form a major part of the workforce for some public services – particularly health and social care – partly as a result of Brexit and of many returning home during the pandemic. The number of people applying for initial teacher training rose sharply in the summer of 2020 and the number of vacancies for adult and children's social care workers fell. Exit rates for prison officers also fell.

This helped to ease the recruitment and retention problems that existed before the pandemic in many of the services that we look at. However, this positive effect is already starting to wear off in some areas – for example, the number of people applying for teaching courses has fallen in 2021. The government will still need to address issues of pay and working conditions that existed before the pandemic.

In some cases, Covid has created more stress and burnout among staff, which could contribute to even greater problems retaining people. The number of days that NHS staff took off due to mental health rose during the spring and winter coronavirus peaks to become the leading single cause of staff absence (notably, ahead of 'flu-like symptoms'); mid-seniority teachers and head teachers report increased intentions to leave teaching; chief inspectors also now say they are more likely to consider leaving the police force; a large proportion of police officers report experiencing poor mental health.

The supply of social care workers will also be constrained by the new immigration rules that have been brought in since the UK left the EU. Only qualified social workers from European Economic Area countries are now eligible to use the fast-track visa route.

Following the 2008 financial crisis, the government imposed pay freezes in the public sector to help achieve spending cuts. But this ultimately led to problems recruiting and retaining staff in many services. The government has announced above-inflation pay rises for some NHS staff but pay for staff in most other public services is still to be determined. Adopting pay freezes again as the chancellor seeks to balance the books would be likely to exacerbate these problems.

How are services placed financially for the rest of this parliament?

The chancellor's spending plans are tight

At the beginning of September, the government announced plans for extra spending on the NHS and social care over the next three years to help tackle NHS backlogs and expand eligibility for, and cap the costs of, publicly funded adult social care. But the spending plans that the chancellor has outlined for the rest of this parliament are very tight – particularly over the next two years.

After accounting for money that has already been ring-fenced for the NHS, social care, schools, defence and overseas aid, and removing Covid spending, spending on other 'unprotected' areas of public services will be lower in real terms in 2022/23 and 2023/24 than it is this year, before rising more sharply in 2024/25. This will make it hard to meet rising demands from the growing population and, in particular, the increasing numbers of older people. It will also make it hard to find money to address the rising demands that are likely to be placed on the criminal courts and prisons by the recruitment of 20,000 additional police officers, let alone to clear any backlogs of outstanding work from the pandemic or meet new demands created by Covid.

Some services did not receive enough extra money to cover their costs during the pandemic

Extra money was spent during the pandemic on all of the services we examine. This helped to implement infection control, support providers and in some cases modify services in response to the pandemic. For example, the NHS spent more to implement stricter infection control in hospitals; schools spent more on PPE, cleaning supplies and digital equipment; prisons spent more on 'isolation pods' and IT; the courts service spent more on improving audio-visual equipment for remote trials; and local authorities spent more on residential care places for vulnerable children, and spent more to prevent widespread closures of adult social care providers.

But although the government spent a lot of extra money on public services, it did not cover all of the extra costs and demands that services faced during the pandemic. It reimbursed schools for Covid costs only where they did not have enough reserves to cover them. The additional £10.4bn provided to local authorities in England did not cover all additional costs and lost income. Over half of local authorities responsible for social care reported making unplanned in-year spending cuts during 2020/21 and almost the same number used their reserves to cover coronavirus pressures. As a result, some local authorities and schools will enter the recovery in a worse financial position than they entered the pandemic.

Recommendations

The government should publish clear plans alongside any money to tackle backlogs

Failing to deal with the backlogs that have built up in public services could well be a false economy. Delaying medical treatment may mean that patients end up with more complex health problems, which cost more to treat or manage. Failing to help children recoup lost learning may leave them with lower skills and weaker prospects when they enter the labour market, with costs for the economy.

Given these risks, the government could allocate funds to help services tackle the backlogs. If it does so, this money needs to be accompanied by a clear plan describing how service operators (such as schools) will find the physical and staffing resources they need to do so. The government's plan to tackle NHS backlogs and reform social care – *Build Back Better: Our Plan for Health and Social Care*, published in September 2021 – is not detailed enough to do so.

To the extent that the funding required to return backlogs to pre-pandemic levels is a one-off, it ought only to be temporary. The Treasury should make clear in the spending review what money is being allocated for the short term to tackle backlogs and what funding will be permanent.

The government should evaluate the impact of new ways of working and new technologies

The government needs to collect more evidence on how the new ways of working and new technologies adopted during the pandemic have affected service users. These changes have the potential to increase the efficiency and accessibility of services, but many people have raised concerns that some of the changes disadvantage some users.

Some legal practitioners, for example, have suggested that court hearings that require input from witnesses, defendants and lawyers do not work as well as in-person hearings, particularly for vulnerable defendants. The Nuffield Family Justice Observatory rapidly evaluated the use of remote hearings in the family and civil courts during the pandemic. It found that remote civil hearings were more effective for matters where the outcome was less contested and where both parties had legal representation. However, its review of the family courts reported that it was "extremely difficult to conduct the hearings with the level of empathy and humanity that… was an essential element of the family justice system".[1] But no similar assessment was made for the criminal courts.

Social workers and parents have reported that remote child protection conferences and court hearings are not as effective for detecting children at risk, and that children and families find it harder to participate in decisions about care and placement remotely.

Departments should evaluate the impact of the changes that have taken place – positive and negative – as quickly as possible, focusing on the impact on users. Those that are shown to be beneficial should be continued, and funding allocated accordingly.

The government should sustain and expand data collection efforts

The pandemic highlighted the gulf between the range and quality of data available in different services. Throughout the pandemic, detailed information was made available on what was happening in hospitals: how many patients were in hospital with Covid, how other types of treatment had fallen, and how many beds were available and where. But this served to highlight the woeful lack of information on many other services, notably social care for children and adults. Basic data on how many children and adults received publicly funded social care during 2020/21 had not been published at the time of this report's publication, and the government still does not collect information on private funding of social care, staff:resident ratios, staff qualification levels in care homes and home care, or what happens to adults who request but do not receive publicly funded adult social care. This is a cause of concern.

The government, and in some cases membership bodies, acted quickly to roll out rapid surveys in specific areas to fill key evidence gaps, including on how much extra local authorities spent as a result of the pandemic, care home staffing pressures and referrals to children's social care. This data collection should continue to monitor how public services perform as the pandemic eases, and departments should be given the funding needed to do this.

But the government still needs better information to make decisions, especially in adult social care. No government can make good spending decisions without understanding how its choices affect the performance of services – and, ultimately, their impact on people's lives. The government has acknowledged its lack of social care data in the Health and Care Bill[2] – but has still to clarify exactly what information it will collect. Without better data for all services, there is a danger that attention and money will be directed towards tackling the most obvious problems, rather than the most urgent.

1. General practice

The pandemic created an extraordinary challenge for England's primary care system. During the first national lockdown GP appointments fell to the lowest levels on record, creating a severe backlog in care. Delayed or missed diagnoses duly slowed patients' progression into specialist care – where similar backlogs have, in turn, put additional pressures back on general practice, which is now managing patients who are sicker than before.

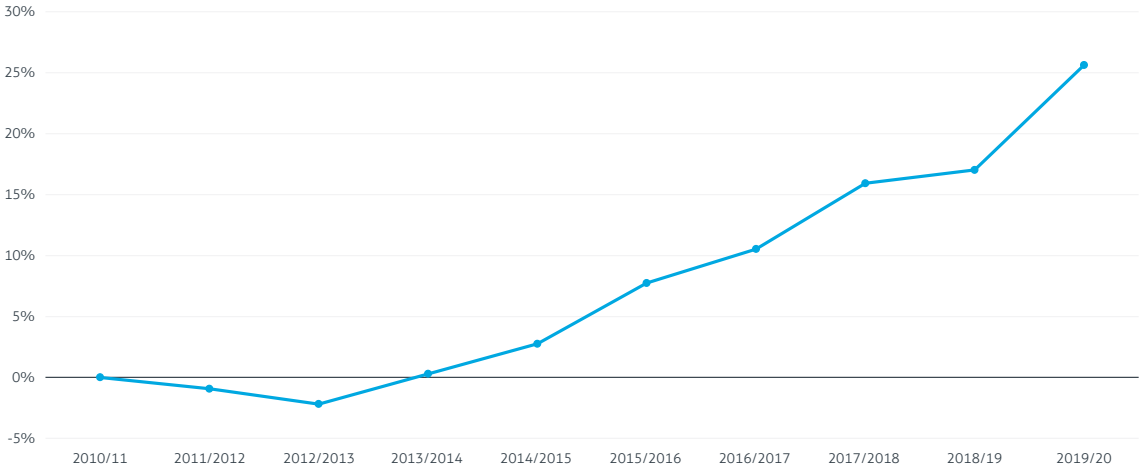
Covid also changed the nature of primary care work. It dramatically accelerated the shift to telemedicine, and from December 2020 general practice also began administering the vaccination programme. Combined with routine appointments and efforts to clear the backlog, the general practice workload is now substantially higher than it was before the pandemic – since December the number of appointments each month has been up 34% on 2019 levels. This additional burden has put strain on primary care staff.

General practice will require more funding to identify and provide care to people whose conditions have been missed or grown worse during the pandemic. But the biggest single constraint on general practice's ability to clear the backlog and return to pre-pandemic performance is staff numbers, with both GP and nurse numbers down on last year.

Staff in general practice address a broad range of medical needs by diagnosing and managing patients' symptoms and conditions, including undertaking consultations for new and existing issues and managing health care for people with complex long-term conditions.[1] If patients require specialist treatment, staff refer them to hospital or specialist units. As such, general practice is the 'front door' of the NHS, and its staff work closely with health visitors, social care staff and charities. This chapter discusses general practice in England.

Spending on general practice has grown steadily since 2012/13

Figure 1.1 **Change in total current and capital spending on general practice in England**



Source: Institute for Government analysis of NHS England, Investment in General Practice in England 2015/16 to 2019/20, 25 March 2021; NHS Digital, Investment in General Practice 2009/10 to 2013/14, England, Wales, Northern Ireland and Scotland, 19 September 2014; NHS Digital, Investment in General Practice 2011/12 to 2015/16, England, Wales, Northern Ireland and Scotland, 21 September 2016.

Spending on general practice rose by 7.3% in real terms in 2019/20 compared to the year before, the largest fastest one-year rise since at least 2010/11. This was the first year covered by the new five-year 'NHS Long Term Plan', agreed by the May government in January 2019.[2,3] This was also the year when the government agreed a new GP contract* – which included a provision to recruit 26,000 additional staff in general practice by 2023/24.[4] This additional spending, along with further increases planned for 2020/21 to 2024/25, was supposed to get primary care onto a more stable long-term footing. But coronavirus changed the context dramatically.

As with hospitals, the crisis required an extraordinary short-term transformation of the primary care system. To support the NHS through this the government authorised additional spending – although it is not possible to assess how much extra general practice spent in comparison to 2019/20, or whether it was enough to meet additional Covid demands, as publications of the year's annual accounts have been delayed.** In July 2020 the government's Plan for Jobs provided £5.5bn additional spending for health services[5] including allocations to "keep our pharmacies and GP practices open during bank holidays".

* GP services are provided by practices and private enterprises that provide primary care. The NHS reimburses practices for the services they provide on a contractual basis. This is periodically renegotiated, most recently in 2020. The GP contract outlines the obligations and fees relating to primary care.

** Figures on public spending on general practice are released annually. Spending figures for 2020/21 were due to be published in September 2021 but depend on the DHSC and NHSE&I annual report and accounts, which have been delayed. See www.england.nhs.uk/gp/investment/investment-in-general-practice-in-england-2015-16-to-2019-20-data-quality-statement

This was followed in September by the Winter Economy Plan, which provided a further £8.9bn to "support capacity and services in the NHS",[6] although the government did not specify how it would allocate this money between different services. Portions of this funding which were allocated directly to primary care included:

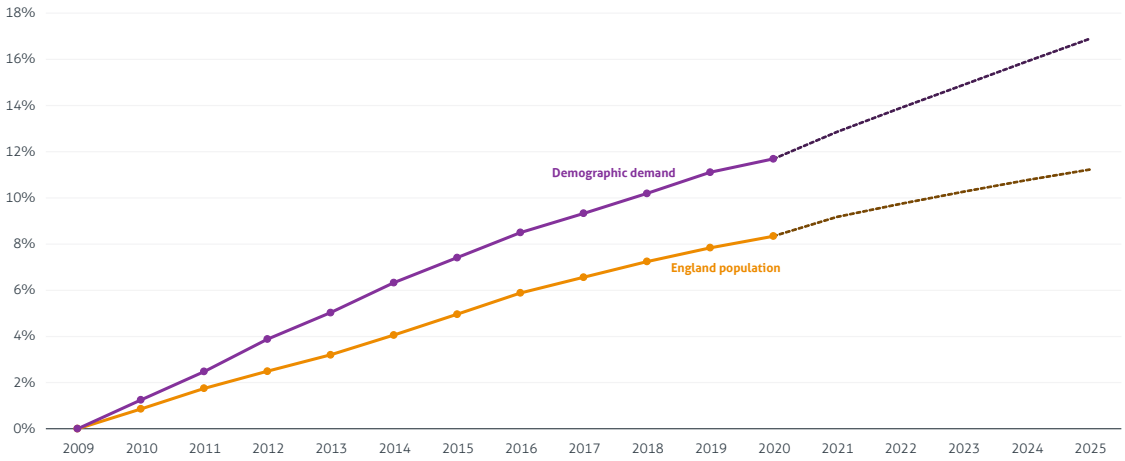
- **August 2020:** the Covid-19 Support Fund for general practice is established to assist with additional costs arising from the coronavirus response.[7]

- **November 2020:** the General Practice Covid Capacity Expansion Fund provided an additional £150m until March 2021.[8] This covered costs such as: hiring more GPs, identifying and supporting patients with Long Covid and addressing the backlog in care.

- **March 2021:** the General Practice Covid Capacity Expansion Fund receives £120m in extension funding to support practices from April through September 2021.[9] This money was earmarked for supporting the ongoing response to Covid, tackling care backlogs and delivering the vaccination programme.

The pandemic has increased demand for primary care

Figure 1.2 **Cumulative annual and projected change in England's population and estimated demographic demand for primary care (%)**



Source: Institute for Government analysis of Office for National Statistics, Household projections for England: 2018-based, 29 June 2020; Office for National Statistics, Population Estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2020, 25 June 2021; Department of Health and Social Care, Resource Allocation: Weighted Capitation Formula, 8 March 2011.

The underlying demographic demand for primary care only grew by 0.5% in 2020, the slowest rate since at least 2009. This slowdown is due to short- and long-term trends shaping England's population structure. The size of the cohorts which need the most care either grew at a slower rate (65+ years old) or contracted (0–4 years old) in 2020. The pandemic, however, has driven demand for primary care and GP activity far higher and far faster than these demographic trends on their own would suggest.

In the coming years the underlying demographic demand for care will continue to grow. There will also be additional ongoing pressure on primary care from the legacies of the pandemic that include: care backlogs, an ongoing coronavirus vaccination programme, delayed diagnoses of serious medical conditions, Long Covid and a higher prevalence of mental health conditions.[10,11]

England's population is both growing and ageing. This has driven increases in underlying demand and government spending on primary care since at least 2009.[12] Demographic changes have increased demand for primary care 11.7% overall over this period, 1% annually on average. This trend will continue. Because the age structure of the population is trending to be increasingly old (with a particularly large 50–64 year old cohort) we expect the underlying demographic demand to grow faster than the overall size of the population.

The greatest demand for primary care comes from people aged 65 and over. This group only grew by 1.2% in 2020, the lowest rate in a decade. However, the vast majority (89%) of coronavirus-related deaths in England have been in people in this group. As of mid-August 2021 the death figure was equal to 1% of the total size of the cohort in 2020 – effectively slowing the growth of this group, although not actively contracting it as an overall share of the population.[13]

Another group that creates high demand for primary care is children aged 0–4. However, birth rates have been declining since 2016, and this age group shrank by 1.8% in 2020, faster than any of the previous years. England's ongoing 'baby bust' was exacerbated by the pandemic, which saw fertility rates fall to historic lows.[14] Some of this was driven by the pandemic and lockdowns, but non-Covid factors, such as a shift in working patterns, may have reduced fertility rates and will likely continue to do so in the long term.[15]

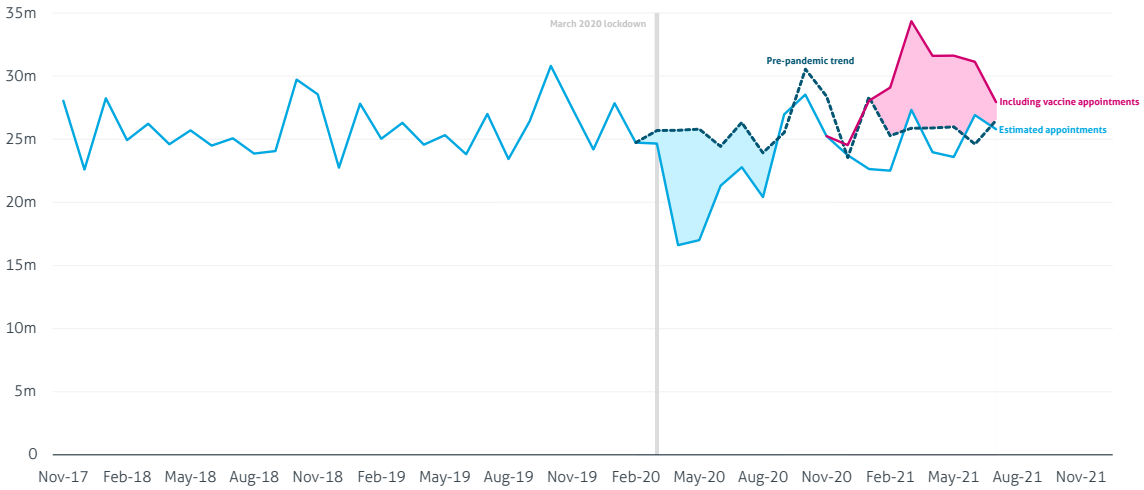
The emergence of Long Covid could also create additional demand on general practice if sufferers experience significant and widespread chronic health problems, though the full extent of this is yet to become clear.[16,17] The number of people suffering with some form of Long Covid (which currently lacks a robust medical definition)* could be as high as 945,000[18,19], which would be more than the number estimated to have COPD** (~850,000), epilepsy (~600,000) or Parkinsons (~127,000).[20]

* The closest commonly used definition is Covid symptoms persisting for more than four weeks after the first suspected infection that were not explained by something else.

** Chronic Obstructive Pulmonary Disease.

Primary care activity dipped during the first wave, but GPs are now busier than before the pandemic

Figure 1.3 **All appointments in general practice (England)**



Source: Institute for Government analysis of NHS England, Appointments in General Practice July 2021, 26 August 2021. Appointment numbers are estimated from the total number booked (monthly) and the percentage of practices covered by the NHS England survey.

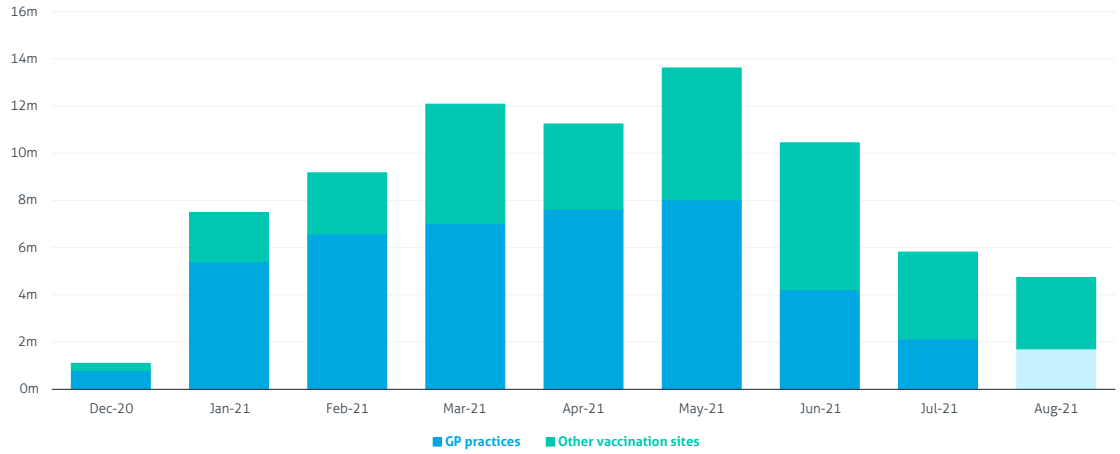
There were many fewer appointments than normal during the first lockdown; the numbers in April and May 2020 were about 60% of what is expected for that time of year. This reduction was mainly due to reduced demand. The NHS's survey of GP patients suggested that 42.3% had avoided making an appointment in 2020,[21] due to concerns about burdening the NHS (19.8%) and the risk of catching coronavirus (17.3%). The biggest falls in the number of appointments during this period were for 11–19 year-olds, which reflects the lower prevalence of communicable diseases and injuries arising from sports and play while schools were closed.[22]

Other primary care activity held up during the pandemic. Routine early-years immunisation programmes carried on during the pandemic. Coverage rates for the main vaccines administered by 12 and 24 months were maintained in pre-pandemic ranges.[23] There was a surge in repeat prescriptions shortly before the first lockdown in March 2020 (similar to that seen before Christmas every year, as GPs and patients try to ensure that they will have enough medication to cover them). But subsequently repeat prescriptions have been dispensed at a similar rate as before the pandemic. There were, however, fewer new prescriptions, following the overall reduction in (particularly first) appointments.[24]

By September 2020 the number of GP appointments was back up in line with pre-pandemic levels.* From December 2020, GP surgeries took a lead role in the distribution of coronavirus vaccines[25,26,27] and GP-led vaccination services provided the bulk of appointments for coronavirus vaccines at the start of 2021.[28]

The number of GP-led vaccine appointments has decreased over time as other types of vaccination site have been added, from a peak of 8 million in May 2021 (59% of the total), down to an estimated 1.7m in August (36.3%). This continues to be an additional source of work for GPs.** As the NHS gears up to deliver a winter immunisation programme from October 2021, there is unlikely to be much of a break from vaccinations.[29,30,31]

Figure 1.4 **Coronavirus vaccine appointments provided by GP practices and other sites**



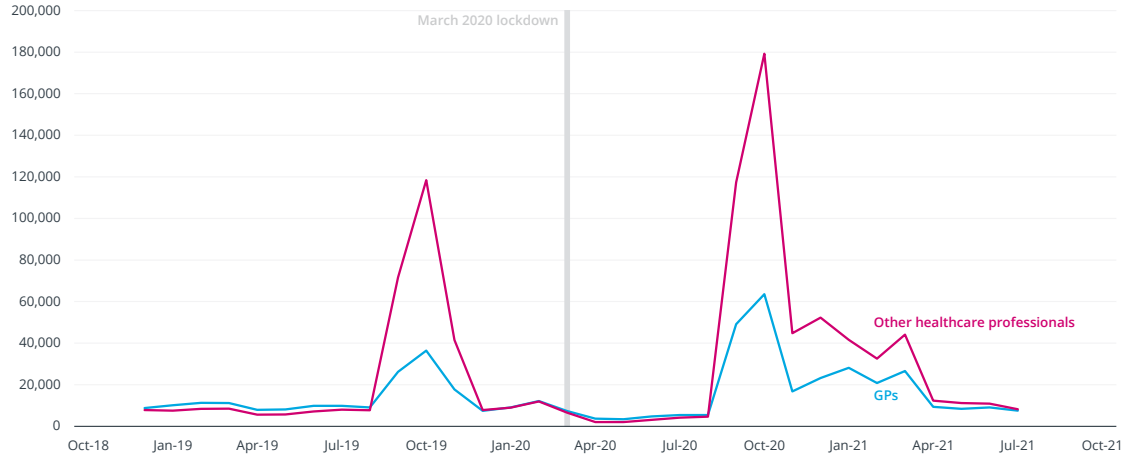
Source: Institute for Government analysis of NHS England, Appointments in General Practice July 2021, 26 August 2021; NHS England, Vaccination Sites, 28 July 2021. We have projected the number of GP vaccine appointments for August 2021.

Throughout 2021, vaccinations have pushed GPs workload higher than before the pandemic – although the number of ordinary appointments remains at or slightly below the pre-pandemic trend. Between March and August 2020 patients booked 32.1m fewer appointments than would have been expected from pre-pandemic trends but this was more than offset by the 41.9m vaccine appointments booked between December 2020 and July 2021. During the summer months – usually a quieter period for GPs – in 2021 practices were delivering a workload they usually only see during October when thousands of extra appointments are provided for winter immunisation programmes.

* The NHS England time series for appointments only goes back as far as November 2017, with robust data from December 2018 onwards. We cannot fully assess the longer-term trend, although there is some evidence that the number of appointments are rising over time in line with the increase in underlying demand. See Atkins G, Davies N, Wilkinson F, Guerin B, Pope T and Tetlow G, *Performance Tracker 2019*, 11 November 2019, Institute for Government, www.instituteforgovernment.org.uk/publications/performance-tracker-2019.

** As of 28 July 2021 there were ~2,144 vaccination sites listed in England. 872 GP-led vaccination services, 416 hospital hubs, 678 pharmacies (as part of a hospital hub), 10 pharmacies (not part of a hospital hub, and 168 other vaccination centres (e.g. sports stadiums, theatres, churches and shopping centres). Data validation was complicated by postcode errors in the NHS England dataset. Source: NHS England, Vaccination Sites, 28 July 2021, NHS.UK, www.england.nhs.uk/coronavirus/publication/vaccination-sites

Figure 1.5 **Weekend appointments in general practice, monthly**



Source: Institute for Government analysis of NHS England, Appointments in General Practice July 2021, 26 August 2021.

The imperative to deliver vaccines means that practices have been operating extensive weekend services. In England weekend appointments form part of 'out-of-hours' services, and typically accounted for less than 1% of all attended appointments in primary care before the pandemic. Between September 2020 and March 2021 the weekend share grew from 1.5% to 4.3% of all appointments for GPs and 2.8% to 11.4% of all appointments for other healthcare professionals in practices.

Funding for this programme was provided as an 'enhanced service', using the seasonal influenza vaccination programmes as a model. NHS England and the British Medical Association (BMA)* agreed a service fee of £12.58 for each coronavirus vaccination dose, 25% more than the comparable fee for influenza.** This fee is paid on the completion of the final dose.[32] The implied cost of this between December 2020 and August 2021 is £493.3m.*** In March 2021 NHS England confirmed that it would provide £120m in additional funding to support general practices between April and September 2021, although this was not exclusively for vaccination efforts.[33]

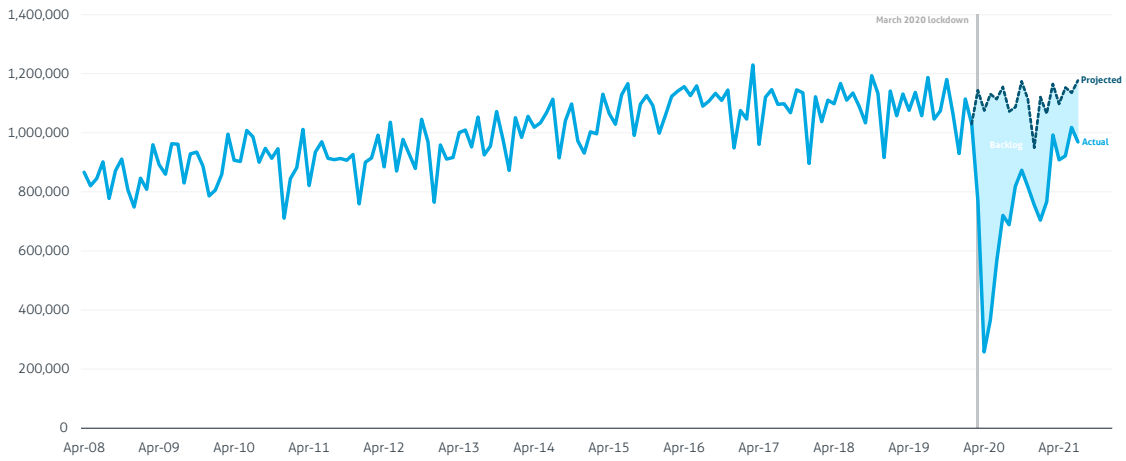
* The BMA is a major trade union and professional body for doctors in the UK that often negotiates on their behalf, including the GP contract for 2020/21 to 2023/24.

** A service fee is the amount the NHS pays to a GP practice for delivering an instance of a particular service.

*** During this period 43.6m doses of vaccine were administered by GP practices. As of 28 September 2021 92% of the English population who have received a vaccine have received both doses. For the indicative cost we assumed 90% of patients completed their final dose in the period.

The pandemic created backlogs in primary care

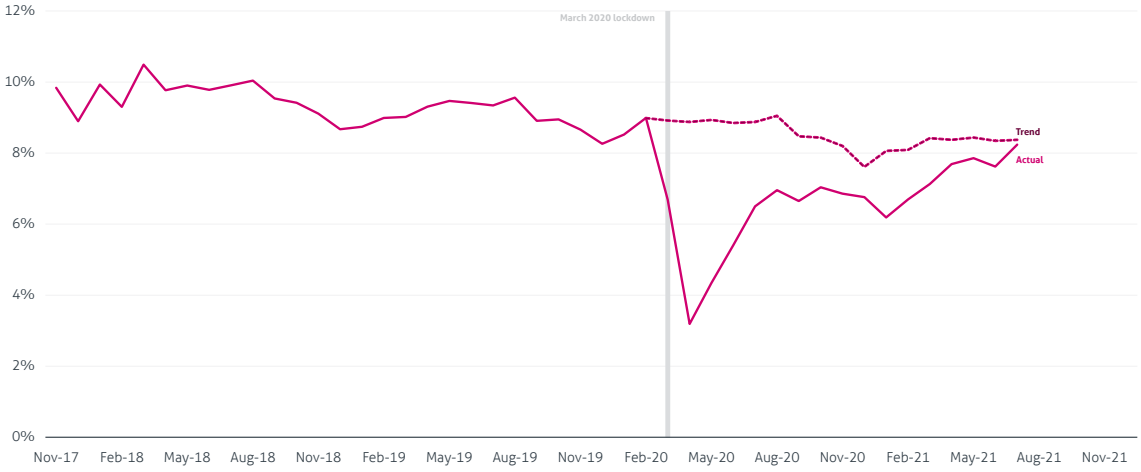
Figure 1.6 **Monthly GP referrals to specific acute care**



Source: Institute for Government analysis of NHS England, Appointments in General Practice July 2021, 26 August 2021.

One role of primary care is to identify and diagnose chronic conditions and refer patients on to acute (specialist) care in a hospital. The number of GP referrals has grown steadily over time, by 2.3% on average every year between 2009 and the start of the pandemic, as underlying demand has grown. Referrals to specialist care fell sharply during the first wave of the pandemic. In part this was because fewer patients made and attended appointments. But hospitals also actively discouraged referrals during this period to avoid being overwhelmed; GPs responded to this. We estimate that between March 2020 and July 2021 there were more than six million fewer referrals than there would have been in the absence of the pandemic.

Figure 1.7 **Referral rate from attended appointments with a GP**



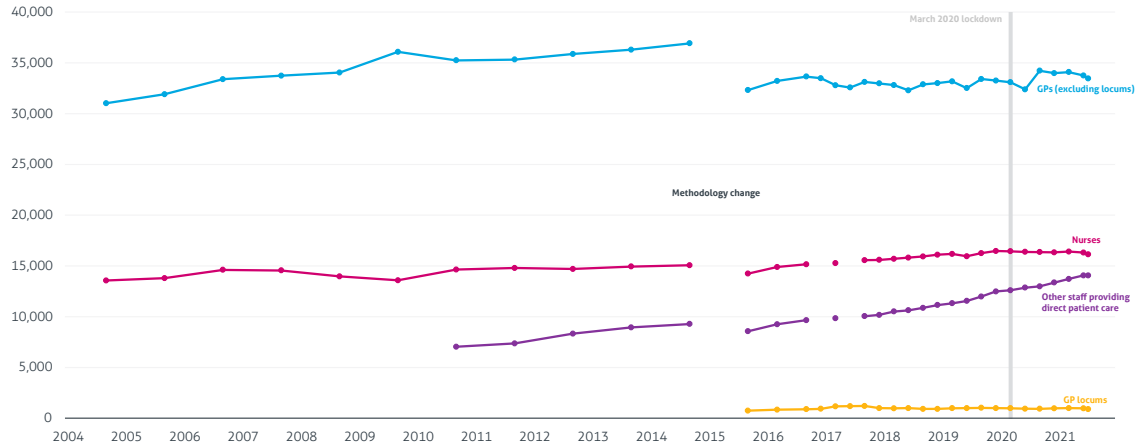
Source: Institute for Government analysis of NHS England, Appointments in General Practice July 2021, 26 August 2021.

The rate at which GPs referred patients to treatment was falling prior to the pandemic, as a result of policy choices that aim to reduce the number of people requiring hospital treatment by making more effective use of alternative sources of care. At the start of the pandemic, the referral rate* fell by almost two thirds, from 9% in February 2020 to 3.2% in April 2020 and has not fully recovered since. This created problems for primary and acute (specialist) care.[34] Virtually all (95–96%) of the GP referrals made in any given month are for specific acute care provided in hospital. Delays therefore mean that many patients' conditions have worsened creating requirements for more complex (and expensive) treatments.[35] Without a GP referral they may have had to enter specialist care through emergency referrals, with a worse prognosis than if they had been diagnosed earlier.[36,37,38] So far evidence of the full impact of these delays is limited, although studies of some cancers shows how conditions have worsened.[39]

At the same time, backlogs in specialist care shift pressure back onto the primary care system. GPs are responsible for the day-to-day management of many chronic conditions and when patients do not receive specialist care these generally get worse and harder to manage. As such, the backlogs in primary and specialist care are closely linked.[40] This is unlikely to change any time soon: hospital capacity remains constrained and waiting lists have grown substantially.**

The primary care workforce has grown

Figure 1.8 **Size of job groups within the primary care workforce (FTE)**



Source: NHS Digital, General Practice Workforce, England, Bulletin Tables, December 2015 – March 2021, 6 May 2021; NHS Digital, General and Personal Medical Services, England – 2004-2014, As at 30 September, 25 March 2015.

In July 2021 there were 133,919 full-time equivalent (FTE) staff working in general practice.[41] This was up from 113,288 in September 2015, but slightly down from the peak of 134,725 in June 2021.[42] While the overall size of the primary care workforce has been stable for the past few years there is a broad consensus that it is understaffed to meet current and future demand – reflected in successive government targets to boost workforce numbers.[43,44,45]

* We calculate this as referrals to specialist acute care as a percentage of attended GP appointments (rather than all appointments). While some appointments may generate more than one referral we have no data on this and so make this simplifying assumption.

** See Chapter 2, Hospitals for more on the pressures facing secondary care in England.

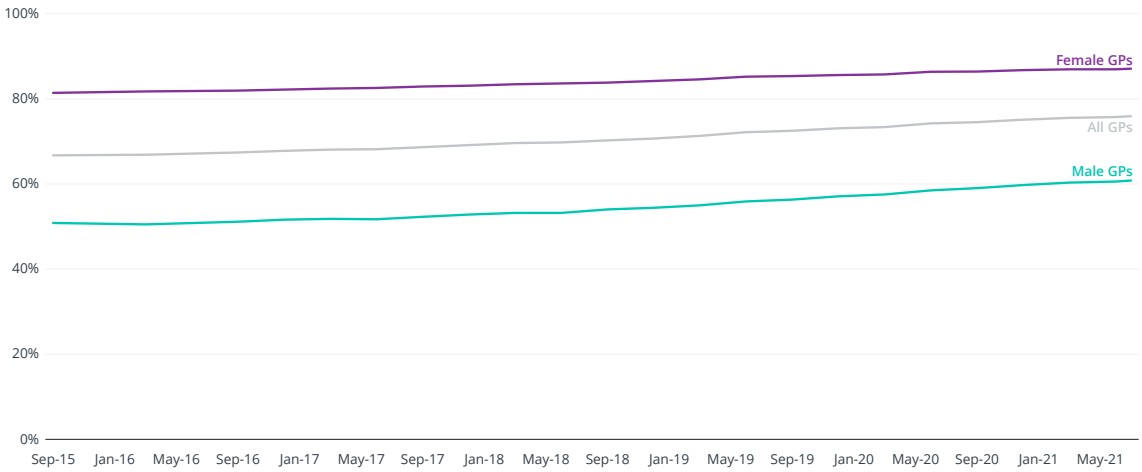
The total number of regular GPs in England has only grown by 3.6% since 2015, despite the underlying demographic demand growing by 5.5% in the same period. The number of nurses has grown by around 13.3% and the number of other staff providing direct patient care has grown by 64.2% over the same period.[46] This latter group includes specialists such as counsellors, physiotherapists and osteopaths.

While the total number of GPs* rose from 39,114 in March 2016 to 42,585 in March 2021, the actual number of hours worked fell: the number of FTE GPs only increased from 33,219 to 33,752 over the same period.[47] This is because more GPs are working part time: some are doing work outside the practice, such as research or teaching; but workload pressures are also pushing more GPs into part-time work.[48,49,50,51]

Because the number of GPs (counted as the equivalent number of full-time doctors) has stayed flat while demand has risen the pressure on individual doctors has increased. The average number of patients per GP has risen from 1,900 to over 2,150 between September 2015 and March 2021.[52] The added workload this creates has been exacerbated by the pandemic. Nine out of 10 GPs report having more work than they expected before the pandemic.[53] The increased workload is in part due to the increase in patient numbers, and in part due to changes in the nature of the workload outlined above.

This trend has damaged the morale and wellbeing of the GP workforce.[54] Doctors, nurses and professional bodies have all voiced concerns about burnout in primary care,[55,56,57] mirroring wider trends across the NHS where the number of staff reporting feeling unwell due to work-related stress was up to 44% in the past year, the highest level on record.[58]

Figure 1.9 **Proportion of regular GPs in England who work part-time (<1 FTE), by gender**



Source: Institute for Government analysis of NHS Digital, General Practice Workforce – 30 June 2021, 5 August 2021.

* All qualified permanent GPs, which excludes registrars and locums.

The proportion of qualified permanent GPs working 37.5 hours or more per week has fallen from 31.9% in March 2017 to 24% in July 2021, while the number working 15 hours or less has increased from 6.2% to 8.2% over the same period. The remaining 67.6% of GPs are working between 15 and 37.5 hours a week.[59]

There is a marked gender split here, with female GPs being much more likely to work part time than their male colleagues. Although the trend towards part time working is true for both, with the share of male GPs working less than one FTE rising from 50.8% in September to 60.8 in July 2021; the equivalent rise for female GPs is from 81.4% to 87.1%. The trend for all GPs is increasing faster too, as the gender balance of the GP workforce skews increasingly female, from 51.9% in September 2015 to 57.4 today.[60] GPs are also getting younger: the share aged under 50 has increased from 58.9% in September 2015 to 63.6%.

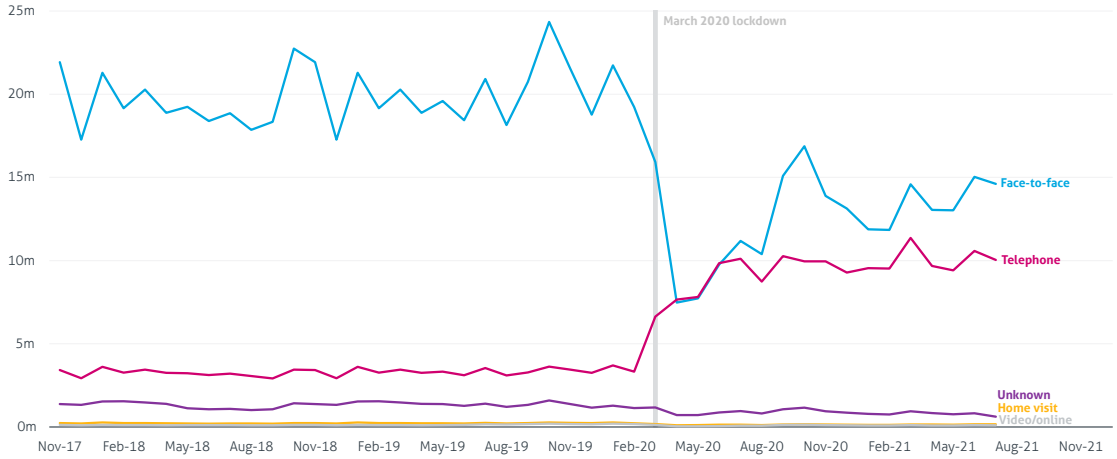
The GP Forward View published in 2016 set a target to recruit a further 5,000 new FTE GPs over five years.[61] This was always going to be a challenge to reach and was ultimately missed. While the total headcount of qualified permanent GPs increased by 1,260 between September 2016 and August 2021. The actual number of full-time equivalent GPs decreased by 1,863.[62,63] The growing share of GPs working part time is the main reason for this.

Despite this the government has pledged once again to expand the primary care workforce, this time with 6,000 more GPs and another 6,000 nurses by 2024.[64] There is limited scope, however, to train or hire new doctors and the global nature of the pandemic is limiting overseas recruitment. In any case, international recruitment is not suited to meet all shortfalls. Community and primary care nursing roles typically require UK-specific additional qualifications as well.[65] Bringing older staff out of retirement or inducing people who have left the profession to return is one option. But doing so will require the NHS to address long-standing concerns about workload and pay, which will have driven some of those people away from the profession in the first place.[66]

The pandemic accelerated remote appointments in primary care

Primary care was already undergoing major changes in practice organisation and care delivery before the pandemic.[67] But, as in other public services, the crisis accelerated the pace of change towards greater use of remote appointments, and better use of technology to integrate practices, share data, and support patient administration.[68,69]

Figure 1.10 **Monthly appointments in general practice by mode**



Source: Institute for Government analysis of NHS England, Appointments in General Practice July 2021, 26 August 2021. Includes all appointments with GPs and other healthcare professionals working in practices.

One of the first actions NHS England took during the pandemic was to mandate a system of 'total triage'.[70] This directed practices to screen patients either online or over the phone before making an appointment.[71] NHS England encouraged practices to reduce face-to-face contacts by consolidating appointments and promoting remote appointments where possible and appropriate. This policy has been maintained throughout the crisis and will likely be a lasting feature for the foreseeable future.[72]

Remote consultations had not really taken off before the pandemic, although the NHS had made a shift towards "digitally enabled primary care" a key component of its 2019 Long Term Plan.[73,74] The circumstances of the pandemic meant that the NHS and GP practices were more willing to experiment and innovate during the pandemic than before: during the peak of the first wave, between April and June 2020, more GP consultations were done by phone than any other mode; nearly 48% of all appointments each month.[75] This higher tolerance for operational risk allowed practices to streamline existing practices and bureaucracy, with support from technology suppliers to get services up and running.[76] This would have been harder if the NHS had not already invested in this technology; but it is unlikely that the NHS would ever have transformed itself this quickly under normal conditions.

While other aspects of health care have returned (or are in the process of returning) to a pre-pandemic status quo, remote appointments remain – their number hit an all-time high in March 2021. We do not expect this shift to fade away. The likely future is one where GPs use different modes to engage with patients in the most effective and convenient way.[77,78,79] Guidance from the NHS specifically aims to preserve the benefits of remote consultations in particular.[80]

Remote appointments can be more convenient for patients, who do not need to travel and increasingly have the option to schedule appointments at a time that suits them. This also has potential benefits for patients who are less able to travel, or are clinically vulnerable and want to avoid contact with other sick people. The benefits of convenience are reflected in the much lower rate of missed appointments.[81] Before the pandemic patients missed around 5.5% of scheduled face-to-face appointments every month. This fell to 3.5% during the first lockdown but has since rebounded.

In contrast, before the pandemic, patients missed just 2% of telephone appointments and this has fallen even lower since the start of the pandemic. Remote appointments allow primary care staff more flexibility in scheduling, make it easier to allocate appointments to the most appropriate members of staff, enable working from home, and facilitate triage at periods of high demand.[82]

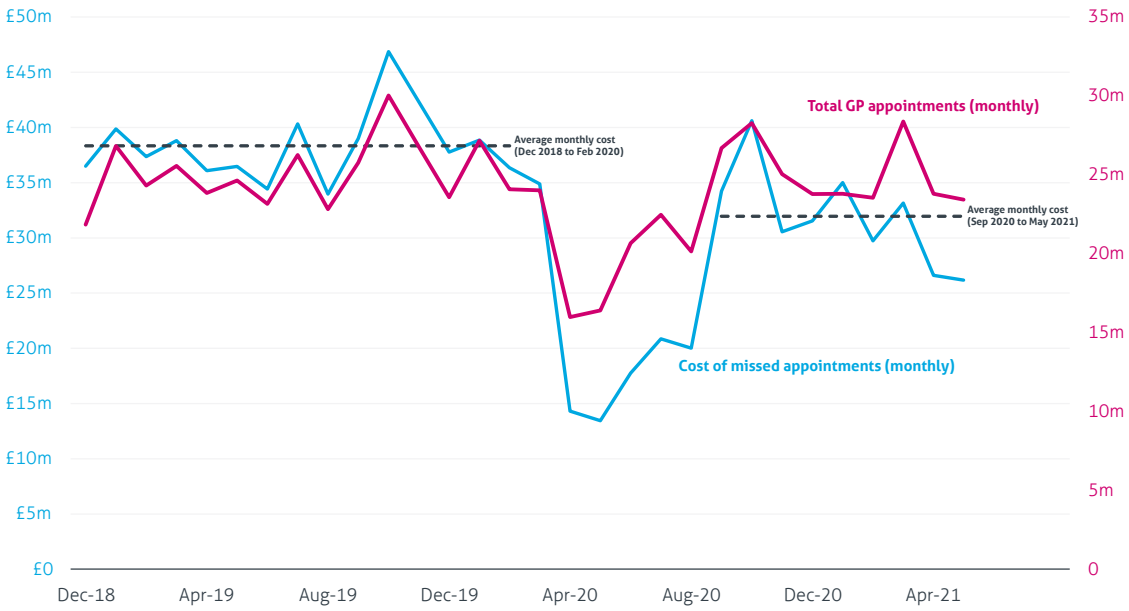
There are some downsides to remote appointments, however – whether by phone or video. Certain types of clinical assessment are more difficult (or impossible) to make over the phone.[83,84] It is more difficult, for example, for staff to detect signs of serious issues such as domestic abuse through remote consultations.[85] Remote appointments are less accessible (or completely inaccessible) to individuals who lack internet access, or are uncomfortable with technology.[86] This group includes many people who have the greatest care needs.[87] Remote appointments may generate more follow-ups than face-to-face appointments, increasing costs. There are also concerns about the quality of remote diagnoses, and the risk of doctors prescribing medications 'just in case' without being able to provide a full examination.[88]

GPs have made more extensive use of remote appointments than other practice staff.* Prior to the pandemic 18.2%** of GP appointments were done over the phone. This rose to 55.9% over the period from March 2020 to May 2021. In contrast only around a quarter of appointments with other practice staff are currently being done remotely, reflecting the different nature of the work done. GPs do more consultations and spoken examinations, while other practice staff are more likely to be administering treatments or therapies necessarily done in person, such as immunisations or blood tests.

* Due to data collection issues NHS Digital aggregates non-GPs into a single category which includes: practice nurses, district nurses, health visitors, physiotherapists, osteopaths, interpreters, link workers, dispensers, counsellors, community psychiatric nurses, chiropodists, acupuncturists and 'other practice staff'.

** Average for October 2018 to February 2020.

Figure 1.11 **Estimated monthly cost of missed appointments in general practice**



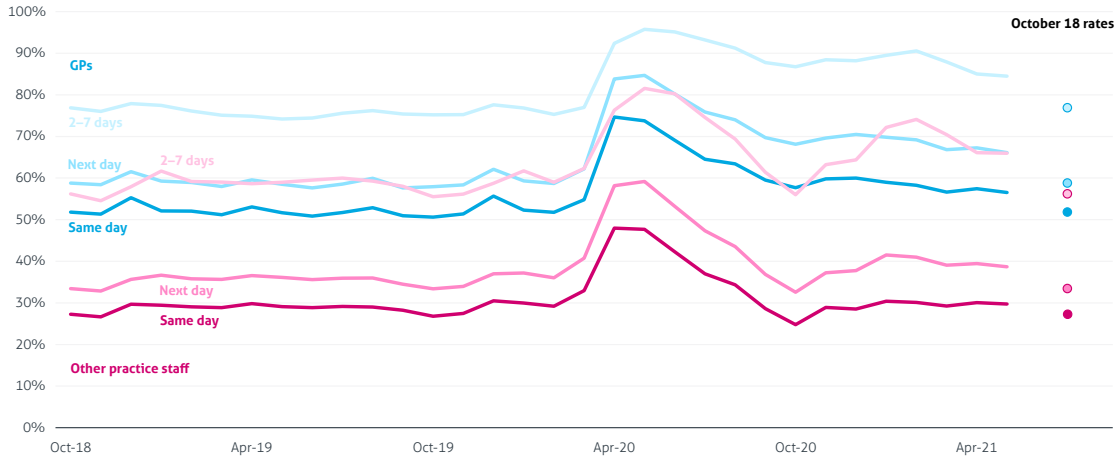
Source: Institute for Government analysis of NHS England, Appointments in General Practice July 2021, 26 August 2021.

Before the pandemic patients missed around 5.1% of all appointments every month.* This costs the NHS £38.3m per month on average.[89,90,**] The NHS has been trying to solve the problem of missed appointments for a long time with mixed success; low-cost strategies have been particularly hard to develop.[91,92,93] Behavioural approaches and automated reminders (the NHS uses SMS-based systems) have offer some benefits.[94,95,96]

Since September 2020, the total number of GP appointments carried out has returned to pre-pandemic levels, but the continuing greater use of phone consultations means that fewer appointments are missed – almost a percentage point down, at 4.2%, on average. This means the monthly cost of missed appointments has fallen by £6.4m to £31.9m.*** This saving equates to around 0.5% of total spending each year on general practice – although this benefit may be partly offset depending on the number of additional follow-up appointments that phone consultations generate.

* This contrasts to 5.5% of missed appointments for just GPs.
** NHS England estimates that the average cost of a GP appointment is around £30. Average monthly combined cost of missed appointments from December 2018 to February 2020 was £38,336,852.
*** Average monthly combined cost of missed appointments from September 2020 to May 2021 was £31,962,037.

Figure 1.12 **Share of appointments in general practice by waiting time**



Source: Institute for Government analysis of NHS England, Appointments in General Practice July 2021, 26 August 2021.

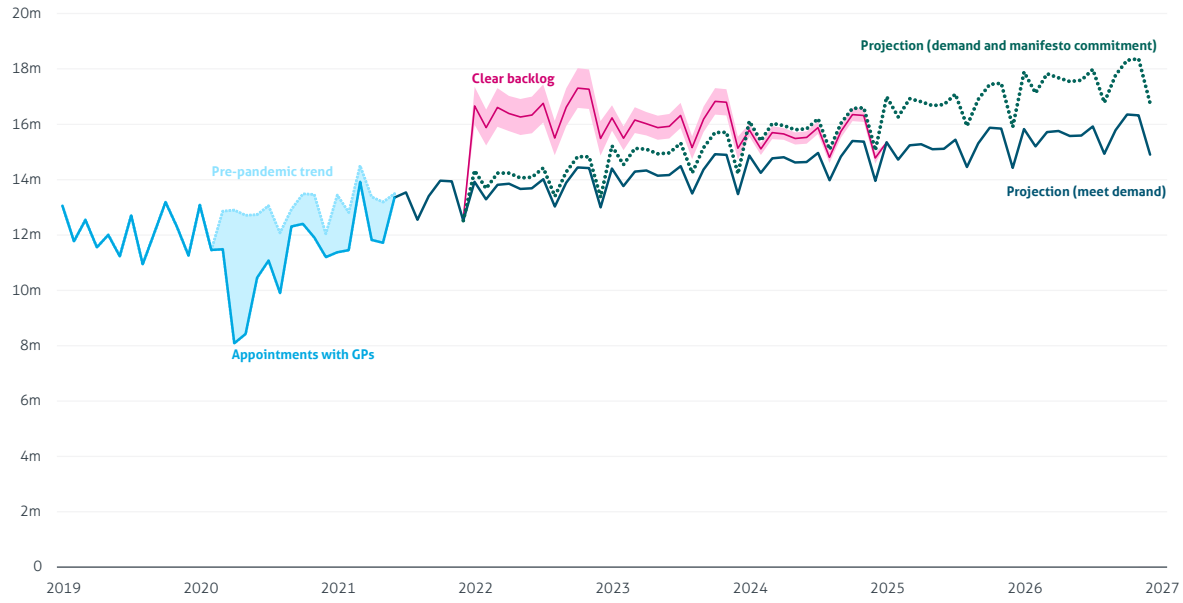
The ease of scheduling remote appointments is reflected in the higher-proportion of same-day telephone appointments compared to other types of consultation. For both GPs and other practice staff the proportion of all appointments that were on the same day, next day, or within 2–7 days of booking rose during 2020. These reduced waiting times, especially for GPs, have persisted, and are uniformly shorter than waiting times prior to the pandemic. Notably, quicker appointments don't seem to come at the expense of quality – a growing proportion of patients reported a positive experience of GPs in the latest survey.[97] Correspondingly the proportion of appointments that came 28 days or more after booking fell from a pre-pandemic average of 3.0% to 0.8% (average June 2020 to May 2021).

How much would it cost to address the legacy of the pandemic in general practice?

Demand for primary care will continue to rise over the coming years as the size and relative proportion of the UK's population that is elderly continues to grow. There will also be increased demand stemming from care needs which went unmet during the pandemic (the backlog), the need to provide an ongoing coronavirus immunisation programme, and greater prevalence of new health conditions (such as Long Covid) and existing ones (such as mental health conditions). The Health Foundation has estimated that primary care activity would have to rise 1.4% per year between now and 2024/25 to meet underlying demand pressures.[98]

General practice capacity to meet existing demand was already limited. Overcoming this additional demand creates an added challenge for GP practices that they will need new and expanded resources to solve. The primary care system is constrained in many of the same ways as hospitals. In particular, the NHS cannot train or recruit new staff fast enough to meet demand. Physical capacity in practices is less of an issue than it is in hospitals, especially given the effective use of remote appointments.

Figure 1.13 **Historical and projected demand for primary care appointments**



Source: NHS England, 'Appointments in General Practice July 2021', 26 August 2021. Institute for Government health model.

The number of GP appointments that the NHS will need to deliver to meet both rising demand and manage the backlog depends on numerous factors. Most crucial are: the length of time over which the effort to clear the backlog can be spread; the rate at which GPs refer patients on to specialist care; and the real number of missed referrals which still require care.

In Figure 1.13 we have spread the backlog over three years (50% in the first, then 33%, then 17%). The upper and lower bounds represent 125% and 75% of our estimate of six million missed referrals (the central line). This projection also assumes that the rate of referrals recovers to the pre-pandemic average of 9.4%. Since the first lockdown GPs have been referring patients at a lower rate, equal to about 7.4% of appointments.

The NHS would need to provide around 64.2m additional appointments to clear a backlog of six million referrals, at a rate of 9.4%. This could be as low as around 48.1m if only 75% of the missed referrals actually need to be delivered. Or it could be as high as 80.2m if the number of referrals is actually 25% higher than estimated. A higher estimate is plausible if we accept – as evidence suggests – that the pandemic has also spurred a wave of excess mental health issues.

This projection is intended to illustrate of the size of the problem. In practice the number of patients who return will vary, and the timeframe over which they need to be seen will depend on how critical their conditions are. It is likely that – as long as hospital capacity remains constrained – GPs will have added considerations about whether to refer a patient on to specialist care. What seems likely is that the government will need provide resources enough for the NHS to supply tens of millions more appointments over the coming years.

The NHS has limited options to divert demand from primary care at the best of times, let alone during the tail-end of a pandemic. And with the backlog of cases, GPs will need to deliver even more appointments than they might have been expected to otherwise. This transformation will also need to consider a potentially annual coronavirus vaccination programme.

In its 2019 manifesto the government guaranteed that the NHS would provide 50 million more GP appointments per year.[99] The government is still a long way from this target, as it is with other promises, and not only because of the disruption caused by the pandemic.[100] As it stands the number of appointments each month is lower now than when Boris Johnson won his election. Hitting this target will take more resources than have been allocated and cannot be done without hiring more GPs – another target the government is struggling to hit.[101]

There are ways for the NHS to make the primary care system more efficient, some of which are already being implemented. Remote consultations have the potential to save costs – by reducing both missed appointments and administrative overheads. However the extent of any benefit depends on the amount of follow-up appointments they generate. There may be other savings that accrue from the use of technology to integrate and support back office functions. Similarly, the development of Primary Care Networks has the potential to deliver some efficiencies of scale. However we do not expect that these effects will be enough to offset the substantial increased costs from rising demand.

If it wants to increase activity, then the government needs to focus on providing resources to hire and retain more doctors and nurses in the near term. Staff is the main constraint on the ability of the primary care system to clear the backlog and manage rising demand. If the government wants to achieve both those goals, spending will need to rise faster than planned.

2. Hospitals

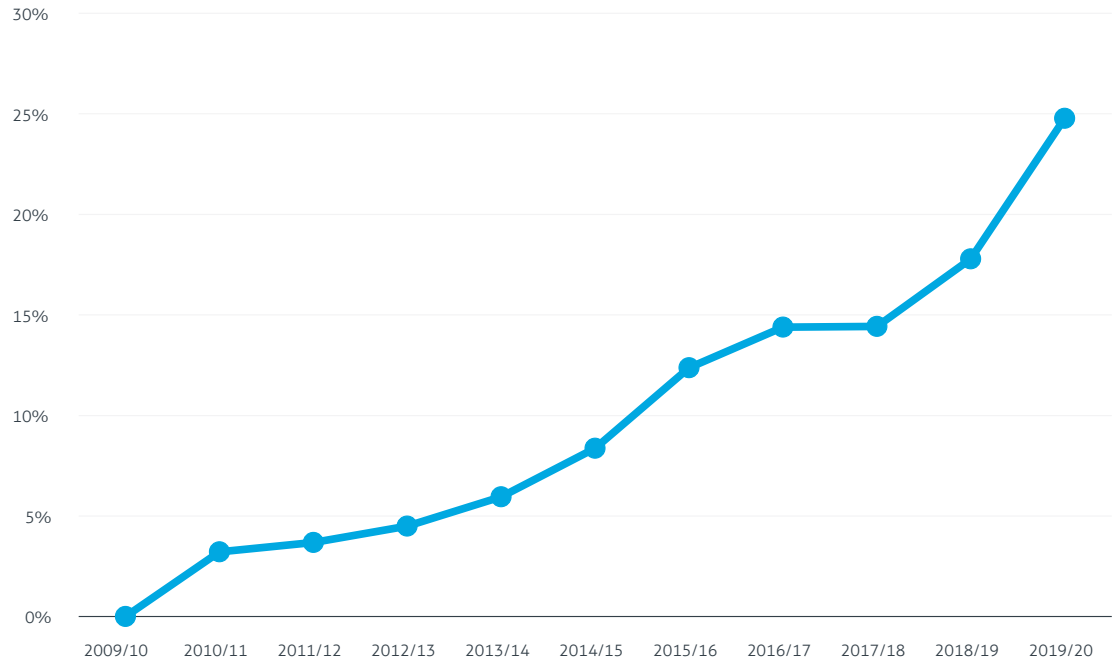
Navigating the pandemic posed an extraordinary challenge for the NHS in England, and for hospitals in particular. Protecting hospitals from being overwhelmed has been a priority for the government throughout the crisis: to do this it has authorised nearly £92 billion in additional spending. Some of this covered system-wide costs, for new services such as Test and Trace and the seven temporary 'Nightingale hospitals'. For hospitals this additional spending expanded capacity through the use of private health care facilities, and allowed them to procure additional goods and services, such as PPE and cleaning.

But at the same time many routine and elective clinical services were suspended, both to manage capacity and protect outpatients from the risk of infection, resulting in large backlogs in care. For patients, delays risk conditions worsening; for hospitals, it means performance against most operational targets falling off, and waiting times shooting up. These factors have left hospitals facing a huge challenge in clearing the backlogs while striving to maintain pre-pandemic service levels.

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 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 was growing at record rates even before the pandemic

Figure 2.1 **Change in total spending on NHS providers in England**



Source: Department of Health and Social Care, *Annual Report and Accounts.*

Spending on NHS providers* was nearly 6% higher in 2019/20 than in the previous year, in line with the NHS's overall expenditure, which grew by 6.1% in real terms.[1] This is the fastest annual growth in spending since 2009/10, principally because it was the first year of the five-year front-loaded funding increase announced by Theresa May's government in 2018.[2] This funding boost mainly paid for more staff – NHS England's largest single cost, accounting for nearly 65% of its spending, rising around 13% in 2019/20. Similar rises were seen in other large spending categories: clinical supplies and services (the second largest) grew by around 6.5% and spending on premises (third) grew by around 10.5%.[3] Spending on in-hospital prescriptions of drugs and medication continues to rise at a rapid rate: up 12.2% in real terms year-on-year in 2019/20, and up 137.9% in real terms since 2009/10.[4,**]

The NHS budget – and by extension the budget for NHS providers – was set to increase in 2020/21, albeit at a slower rate than in 2019/20. At the March 2020 budget, the NHS England budget for 2020/21 was set to increase by only 3% in real terms,[5] although spending in 2020/21 has been much higher after the government promised the NHS "whatever it needs"[6] to cope with coronavirus. The final NHS provider figures are not

* NHS providers is a collective term for NHS trusts and foundation trusts (see: NHS England, NHS provider directory, www.england.nhs.uk/publication/nhs-provider-directory). This is distinct from NHS Providers, which is the membership organisation for these bodies.

** Drug and medication costs have been growing far faster than the NHS's funding allocation. While the NHS has been finding ways to provide better value for money with prescriptions, and use its workforce more efficiently, there will probably be difficult choices ahead. Ewbank L, Sullivan K, McKenna H and Omojomolo D, *The rising cost of medicines to the NHS: What's the story?*, 29 April 2018, The King's Fund, www.kingsfund.org.uk/publications/rising-cost-medicines-nhs

yet available but in February 2021 the government estimated that these would be £7.7bn (9.4%) higher than originally budgeted for 2020/21,[7] and 9.5% higher than in 2019/20.

Some pandemic response costs are short term, but others will stay

Responding to the pandemic required extraordinary financial support for the NHS. In total the National Audit Office (NAO) estimates that an additional £97.4bn was allocated to health and social care between February 2020 and May 2021, £91.6bn of this directly to the Department of Health and Social Care (DHSC).[8] This was delivered through a series of spending announcements including the Plan for Jobs, published in July 2020, and the Winter Economy Plan in September that year.[9,10] Much of this allocation was related to the wider public health response, such as the £38.1bn allocation for the NHS's Test and Trace programme – of which £11.1bn had been spent as of May 2021.

It is not possible to specifically disaggregate spending on acute trusts from these totals. However, major allocations that will have predominantly gone to hospitals include the following:

Short-term capacity and needs

Some spending met near-term and Covid-specific needs. This included the £569m programme to procure 26,000 additional mechanical ventilators between March and August 2020,[11] and the £0.6bn in "capital spending to support modifications to existing premises, such as better oxygen supplies, purchasing medical equipment and IT equipment to enable remote consultations".[12] While there are general benefits from having stocks of new equipment we do not expect that hospitals will need as many ventilators in the future as in 2020.

Similarly, government allocations supported the construction of the 'Nightingale hospitals', temporary facilities set up as an insurance policy against an uncontrolled spread of disease.[13] Costing £466.5m, these never saw more than a handful of patients, despite opening to non-Covid patients in January 2021.[14,15] Most were closed in April 2021.[16]

This specific type of spending has a limited direct bearing on the longer-term profile of resource needs or health care demands that hospitals will face. However the pandemic did highlight long-standing issues with capital spending, such as the backlog of maintenance and other estates issues in hospitals. These have been implicated in reports of hospital-acquired infections (often leading to deaths) during the pandemic.[17]

However, there are gaps between the funding allocated in theory, and what is accessible in practice. The government imposed some conditions on the spending, which has made it difficult for trusts to access these funds; in particular, the requirement to raise their activity levels to 95% of those from July 2019/20.[18] This has been hard as many hospitals are still operating with constrained capacity due to Covid, as we will discuss in more detail later in this chapter.

Infection control and PPE

Hospitals implemented heightened infection-control regimes early in the pandemic and have largely continued these. As long as Covid remains an epidemic disease in the UK these controls will need to remain in place. If (as expected) it becomes endemic, it is likely that some level of enhanced infection controls would be needed permanently. But these would depend on other factors such as the long-term level of risk associated with coronavirus and the nature of England's population, their behaviours and general state of health.

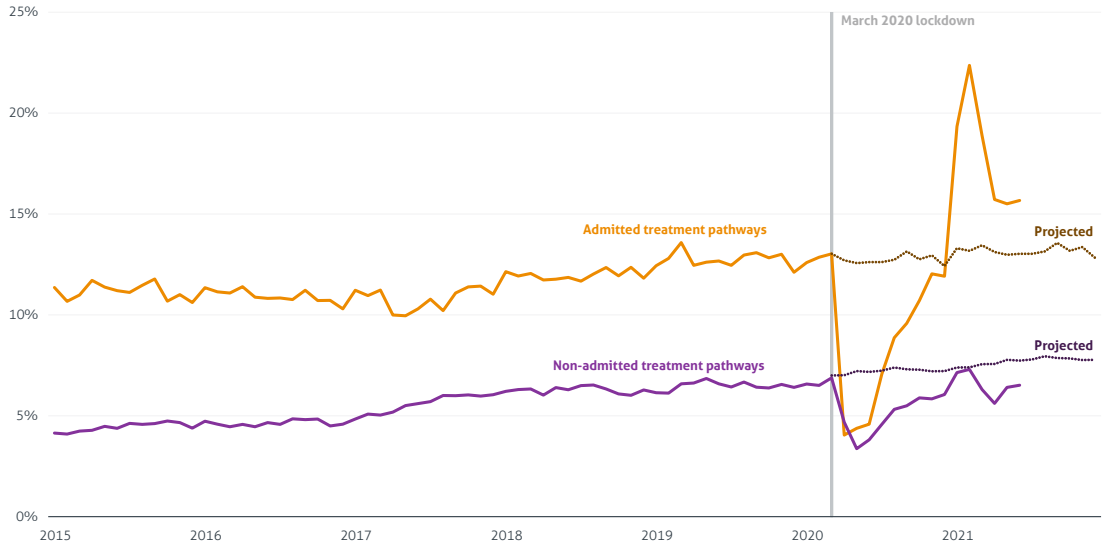
The government took a range of measures to support these changes. The Treasury waived VAT on PPE from May to October 2020, at an estimated cost of £960m.[19,20] The government also allocated £16.8bn to procure PPE for front-line health care staff.[21,22] While this allocation covers the entirety of the NHS, a substantial portion of it will have gone to hospitals. Infection control funding also featured as part of a £2.8bn package within the further £5.4bn of funding the government announced in September 2021 to see the NHS through the winter.[23]

These changes have could incur longer-term costs that will need to be met through additional spending. There are direct operating costs from the procurement of additional PPE for hospital staff, additional cleaning supplies and cleaning services. And hospitals will also face additional capital costs arising from the need to improve ventilation.[24] There are also indirect costs resulting from the way that infection control measures effectively reduce hospital capacity: to reduce the risk of infection, beds are spaced further apart, and other facilities – such as diagnostic suites and operating theatres – have more downtime between procedures to allow for enhanced cleaning.

Independent sector providers

Spending decisions by the government enabled hospitals to make greater use of independent sector providers. The Plan for Jobs allocated £5.5bn for health spending, the bulk of which was used to procure additional health care.[25] Similarly the Winter Economy Plan added a further £8.9bn to "support capacity and services in the NHS".[26]

Figure 2.2 **Share of treatment pathways delivered by independent sector providers**



Source: NHS England, 'Consultant-led Referral to Treatment Waiting Times'.

Treatment pathways are a tool used by hospitals to manage the care of many patients and represent a major area of hospital activity. Non-emergency pathways follow a referral by a consultant and cover patients whose treatment requires admission to a hospital (admitted pathways) and patients whose care needs are resolved without hospital admission (non-admitted pathways).[27,*]

Since 2015 independent sector providers have managed around 11% of admitted treatment pathways and 5% of non-admitted pathways.[28] This share has gradually risen over the last five years and rose substantially during the second wave of the pandemic. During that wave, independent sector providers delivered 22% of admitted pathways, before falling to around 15% in early 2021, where it has stayed. Increased use of independent sector providers is likely to continue for the foreseeable future as the reduction in capacity due to enhanced infection control coupled with backlogs mean that more care episodes need to be managed elsewhere in the UK's health care system.

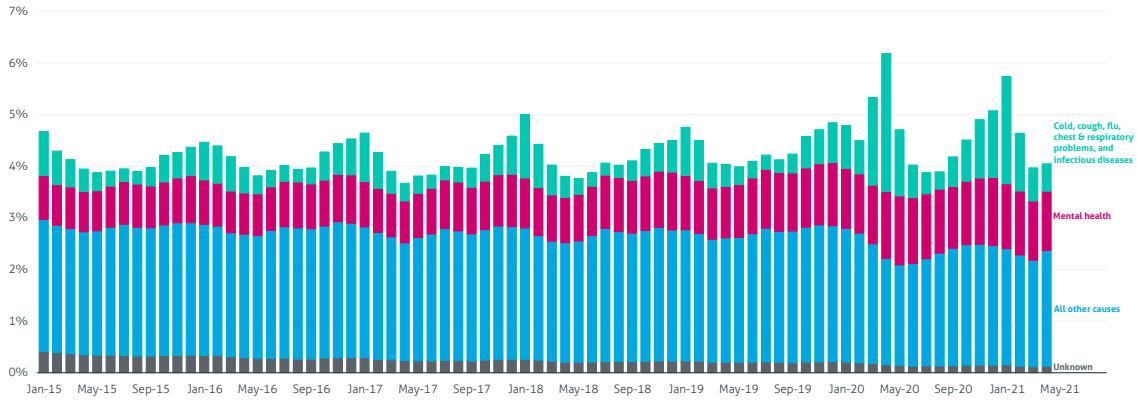
Other spending on health services

Additional funds were allocated over the course of 2020 and 2021. These included £3bn to "support the NHS's recovery from the crisis in 2020-21", £2.4bn in "support for NHS trusts and foundation trusts which have lost income during the pandemic", and £0.5bn in "other central NHS costs".[29] The hope will be that if the UK can avoid a resurgence of the virus, at least on the scale of 2020/21, that these costs should be one-offs.

* The statistics for non-admitted pathways also include patients who stop seeking care or who die while awaiting care.

The pandemic has worsened mental health issues – the main cause of staff absences

Figure 2.3 **Share of all working days lost to sickness (NHS England)**



Source: NHS Digital, 'NHS Sickness Absence Rates, May 2021'.

Since 2015 the NHS in England has typically lost around 4–5% of working days due to staff sickness. This jumped to over 6% in the spring of 2020, during the first wave of the pandemic.[30] Some of this increase can be attributed to staff contracting coronavirus; the share of sick days lost in categories relating to coughs, colds, influenza-like illness, chest and respiratory diseases and infectious diseases all rose dramatically in March and April 2020, before settling down.

Staff were also absent because they were isolating due to potential infectious contacts. Absences peaked on 7 April 2020, when 162,696 members of staff were absent (12.5% of the NHS England workforce), of which 106,597 (8.2%) were directly because of Covid.[31]

While all staff groups experienced marked increases in absence rates during the peak months, doctors were hit particularly hard. Before the pandemic around 1.3% of doctors' working days were lost due to sickness. However, in March and April 2020 this more than doubled, to 2.7% and 3.0% respectively. A similar peak (1.9% and 2.0%) was seen in December and January 2020.

Mental health is the leading cause of staff absences in the NHS.[32,33,34] The share of all sick days due to mental health issues has been increasing steadily over time, from 18% in January 2015 to a (pre-pandemic) peak of 27.7% in August 2019. In June 2020, however, this rose to a peak of 32.4% of all sick days.[35] Part of this rise can be attributed to seasonal falls in other causes of sick days, but even allowing for this the total number of days lost to mental health has risen and remained high. The underlying causes for this are complex and varied, including: stresses arising from having to change roles and manage large critical-care caseloads, excess hours worked, concerns about personal safety, and seeing so many patients struggle – and die – with a novel disease.[36,37,38]

We estimate that there were 2.5 million excess sick days between March 2020 and April 2021 among all NHS staff.* Almost all (94.4%) of these excess sick days came in two three-month periods corresponding to the first and second pandemic waves (March to May 2020 and November 2020 to January 2021).

The trends in sick days for acute trusts are similar to NHS England as a whole. Prior to the pandemic, between January 2013 and February 2020, staff absences in hospitals ranged between 3.5–4.8% monthly, with the same pattern of seasonal variation. The average monthly absence rate was 4%.[39] The average since then has been 4.7%, peaking at 6.5% in April 2020, and then again at 5.7% in January 2021.[40] Doctors have lower rates of absence than other groups, while support staff have higher rates; nurses, health visitors and NHS infrastructure support workers fall somewhere in between.

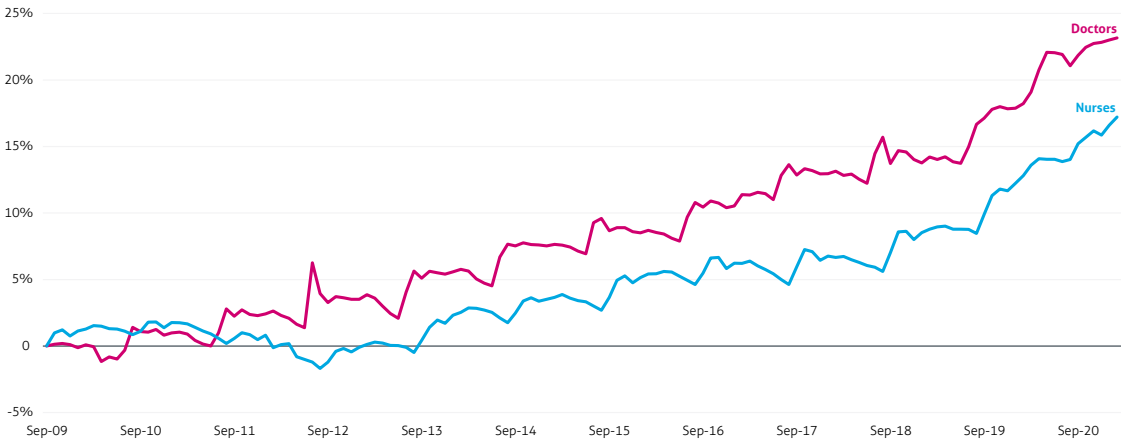
Even before the pandemic there were concerns about staff morale and levels of burnout across the whole NHS workforce.[41] The pandemic has undoubtedly exacerbated this, and the rising share of sick days lost to mental health attests to this. Staff shortages are a major source of stress, poor mental health and burnout in hospital staff – a problem that becomes cyclical, contributing to more staff absences.[42,43,44]

A failure to properly address this will unavoidably lead to long-term consequences for the performance of hospitals. Staff absences due to illness place a constraint on hospitals, and their ability to deliver the amount and quality of care needed. Even if the headline numbers of staff increase, a growing proportion of sick days – especially when those sicknesses arise from working conditions, such as stress or infection – will undercut performance. The NHS cannot simply recruit its way out of this problem. It also needs to dedicate efforts to understand and address the root causes of work-related mental health issues and make changes to help its workforce remain healthy.

* Excess sick days are calculated as the difference between the actual number of staff absences and what we project based on the long-term trend from January 2015 to February 2020.

The NHS England workforce grew faster than ever during the pandemic – but this may not be a long-term trend

Figure 2.4 **Change in number of doctors and nurses (FTE)**



Source: NHS Digital, 'NHS Workforce Statistics, May 2021'.

By February 2021, the number of doctors and nurses in NHS England's workforce was nearly 367,000.* While this group has grown steadily over time, the recent expansion has been larger and more rapid than ever before.

For much of the past decade the number of doctors working for NHS England grew by 1–2% a year, but in April, May, June and July 2020 the figures were 5.7%, 7.2%, 7.3% and 6.0% greater than the year before respectively. Much of this is explained by efforts to recruit retired doctors and nurses to bolster staff numbers as the scale of the crisis became clear.[45,46] Around 15,000 additional staff returned to the NHS during the first months of the pandemic.[47,48] We do not expect this surge to last, and many of the doctors who came out of retirement will presumably return once the crisis eases.[49] However, as of May 2021 no such outflow has appeared in the NHS workforce statistics.[50]

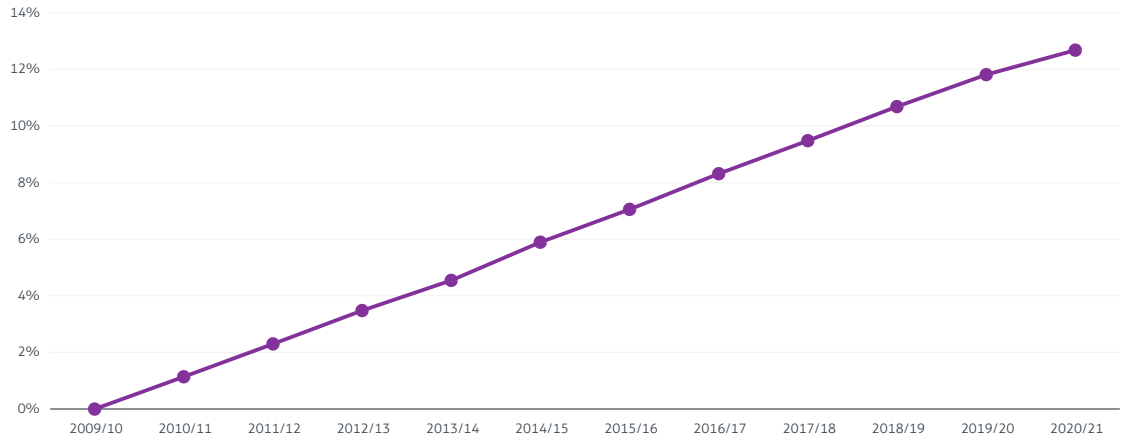
There has been a longer period of steady recruitment of nurses into the NHS since 2012/13, following a major contraction after 2010, but their numbers also expanded rapidly at the start of the pandemic – being 4.6–4.8% higher in April–July 2020 than during the same time period a year before. This was a product of the same recruitment drive that boosted doctor numbers, and is likely to be similarly transient.[51]

The pandemic has not yet had an appreciable impact on staff leaving the NHS. A total of 197,582 staff left the NHS in 2020, which is comparable to the yearly average for 2011–19 (of 201,430).[52] While staff departures remained steady, reported vacancies fell during the pandemic – from a recent peak of 111,864 (full-time equivalent) in June 2019, to 76,082 in March 2021 – although the latest available data shows they have since increased back to 93,806.[53]

* This includes doctors and nurses employed in all types of NHS trusts in England, as data relating solely to acute and specialist trusts is not available.

Demand for hospital services continues to grow

Figure 2.5 **Change in estimated demand for acute care**



Source: Office for National Statistics, Nomis Official Labour Market Statistics, Population estimates/projections, England, 2009–2021; Department of Health, 'Resource allocation: weighted capitation formula', 2011.

The underlying demand for health care is determined by demographic factors – particularly the age structure of England's population.[54] The NHS has determined the relative amounts of resources that individuals in different population cohorts require annually.[55] Using these measures we estimate that the underlying demand for hospital care grew by 0.78% in 2020/21 compared to the previous year – though this is the slowest rate of growth since 2009.

The slowdown in 2020/21 is largely due to below-average growth or active contractions of the population cohorts that create the most demand for hospital services, in particular the elderly. The share of the population aged 0–4 has contracted for the fifth year in a row, reducing demand, and the share of the population aged 80+ grew at the slowest rate since 2009 (0.7% year-on-year growth, compared to an average of 1.9% for 2009–19).

The pandemic will have long-lasting effects on the demand for health care, and the picture is complex.[56] Some are likely to increase demand for hospital services, seen most starkly in the backlog of patients who have unmet care needs. This includes both patients with new conditions that went undiagnosed, and those whose existing conditions worsened due to insufficient management. In both cases these patients will require more complex care.

There are also novel factors that will likely increase demand for hospital services in both the near and long term. The Office for National Statistics (ONS) estimates that, at the start of June 2021, 962,000 people in the UK were experiencing self-reported "long Covid".* This included 471,000 who said their symptoms had lasted for between 12 weeks and a year, and 385,000 for more than a year.[57]

* That is, symptoms persisting for more than four weeks after the first suspected coronavirus infection that were not explained by something else

There has also been a surge in people reporting mental health conditions – either as a result of the pandemic itself or the various control measures the government has imposed, notably lockdowns.[58,59,60] Another consequence of these has been a rise in sedentary behaviour, particularly in elderly and vulnerable populations.[61] This is associated with worse health overall and could well increase demand for medical care.[62,63] These pressures will need to be met by community services such as mental health support and physiotherapy, to avoid a surge in pressures on hospitals in the medium term. Other factors, such as the likelihood that the NHS will have to commit additional resources to the management of endemic coronavirus infections, will probably create sustained, novel pressure.

There are also non-Covid-related trends that continue to put extra demands on the NHS. Multimorbidity (when patients have more than one serious long-term health condition, such as diabetes, COPD* or obesity) is a major challenge for the health service,[64] with around a quarter of adults in England falling into this category. This group accounts for more than half the costs arising from hospital admissions and outpatient appointments, and three quarters of the cost of primary care prescriptions, and has been rising for years.[65,66]

At the same time the crisis has perpetuated (and potentially exacerbated) falling fertility rates, with births falling by 3.9% in 2020 and the first quarter of 2021 relative to the same periods in the year before.[67] This has been described as a 'baby bust'.[68] Covid itself has also, of course, resulted in the highest excess mortality rate in decades, particularly in vulnerable populations.[69,70,71]

Taken together, the size of the most vulnerable cohorts of England's population is smaller than it would have been otherwise. This will reduce the rate at which underlying demographic demand grows relative to what we would expect had the pandemic not occurred. However, the soon-to-be-elderly cohort of 50–64-year-olds is particularly large, and as they age we expect demand for hospital care to grow at a faster rate. On top of this, the added pressures that the pandemic has created, such as the care backlogs and long Covid, mean that overall demand for hospital services will continue to grow over the coming years.

* Chronic Obstructive Pulmonary Disease.

A decline in routine hospital activity created substantial backlogs in care

Figure 2.6 **Hospital activity (actual and projected) and backlogs in care**

Source: NHS England, 'Monthly Diagnostic Waiting Times and Activity', June 2021; NHS England, 'Consultant-led Referral to Treatment Waiting Times Data, 2020–21', June 2021; NHS England, 'Monthly Hospital Activity', May 2020; NHS England, 'Consultant-led Outpatient Referrals', June 2021.

Hospitals responded to the pandemic by postponing or cancelling many of their services – from routine diagnostics and outpatient appointments to elective surgeries.[72,73] This followed directions from NHS England that sought to free up capacity and reduce the risk of infections spreading within hospitals.[74] Though hospitals remained incredibly busy over this period, on many measures of routine activity hospital performance dropped off significantly – particularly during the first wave. While succeeding in freeing up capacity to deal with the worst of the crisis, this has created a large backlog of care.

During the spring of 2020, even before the national lockdown was introduced, many people – particularly the elderly or vulnerable – chose to stay away from hospitals, either for fear of contracting Covid or to 'make way' for more urgent cases.[75] This continued into the year, reducing demand for these services.

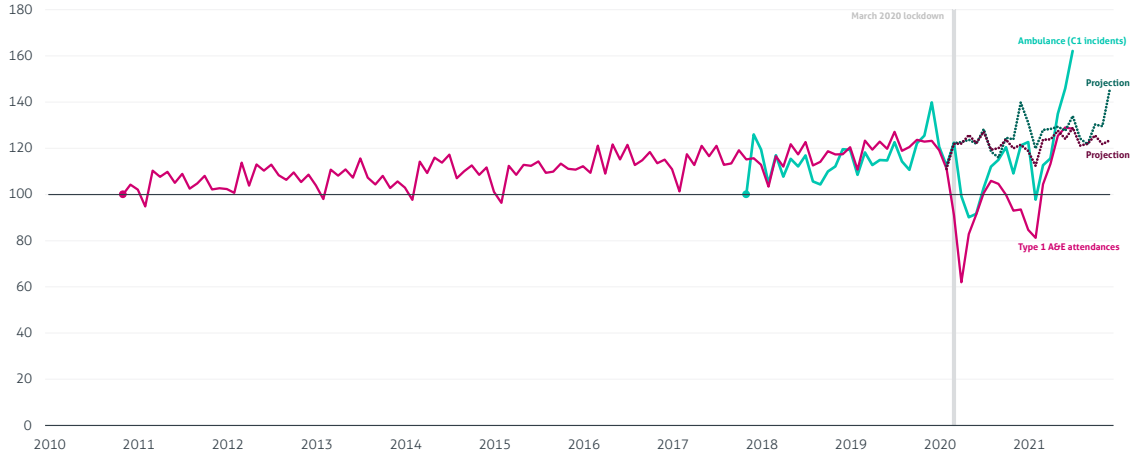
Delays in care are broadly associated with increased health care costs to the NHS and worse health outcomes for patients.[76] This is because treatable conditions are not diagnosed early, when they are easier to manage, and because existing conditions without consistent management grow worse.[77] It is likely that the delays experienced during the pandemic will mean that the treatment or management of these patients will be more complex, less effective and more costly as a result.

We estimate that between March 2020 and May 2021 there were 39.5 million fewer outpatient appointments than there would have been in the absence of a pandemic, and 8 million fewer diagnostic tests conducted. Similarly, there were 1.9 million fewer patients than expected who completed a treatment referral pathway and were admitted to hospital, and 4.2 million fewer patients than expected who began treatment that did not require hospital admission. These numbers do not represent the exact size of the backlog; there are various factors that may reduce it. Some may have sought treatment elsewhere, and it is also likely that some of the un-met demand would have come from individuals who have moved out of the UK during this period. More bluntly, some patients needing care may have died.

Some hospital services, such as critical call-outs for ambulances and A&E admissions, saw reduced activity during the lockdowns but demand has since recovered[78,79] – and is in fact now greater than before the pandemic. The ambulance service had its busiest month ever in July 2021, with more than 82,000 calls for life-threatening conditions.[80] A month earlier, A&E departments had the busiest month on record, with numbers of attendances and admissions that are more typical of the winter months.[81] There are various causes for this surge. Rising coronavirus cases over the summer created additional pressure,[82] while some patients who had stayed away in the worst of the crisis presented to hospitals, often with more advanced conditions.[83] Despite these pressures, however, patients have given A&E departments positive (and improved) ratings since the pandemic.[84]

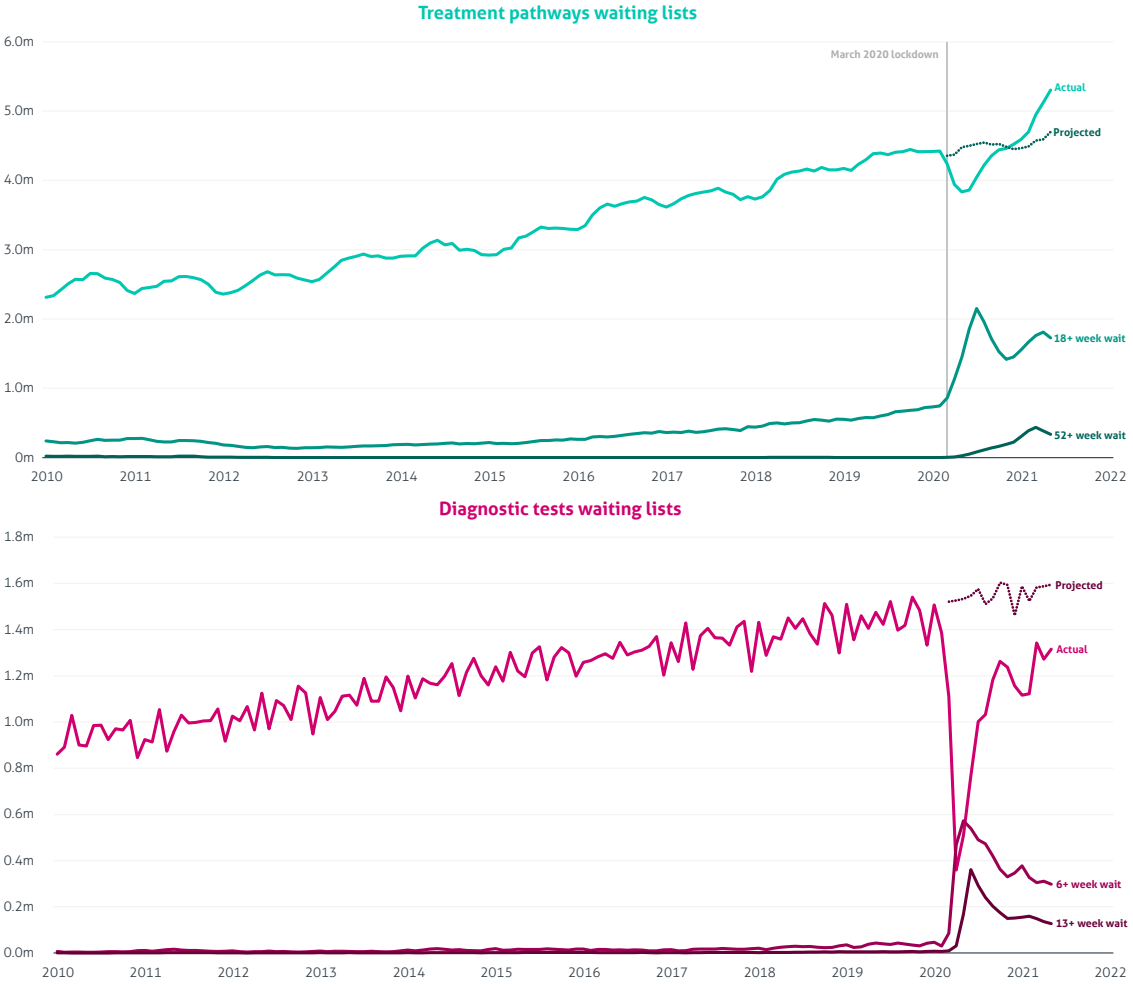
The emergency nature of these services means there is no backlog there as such – though they do play a part in the wider backlog in hospitals. This is because increased ambulance and A&E activity brings patients into already stretched hospitals; for example, by requiring beds that are in short supply.

Figure 2.7 **Relative number of Type 1 A&E attendances and C1 ambulance call-outs**



Source: NHS England, 'Ambulance Quality Indicators', July 2021; NHS England, 'A&E Attendances and Emergency Admissions', July 2021. Type 1 A&E admissions are relative to a November 2010 baseline, and since August 2020 the number of attendances includes those booked through NHS 111. The number of category 1 ambulance call-outs is relative to a December 2017 baseline.

Figure 2.8 **Size of waiting lists to begin a treatment pathway or have a diagnostic test, 2010 to 2021**



Source: NHS England, 'Monthly Diagnostic Waiting Times and Activity', June 2021; NHS England, 'Consultant-led Referral to Treatment Waiting Times Data 2020-21', June 2021.

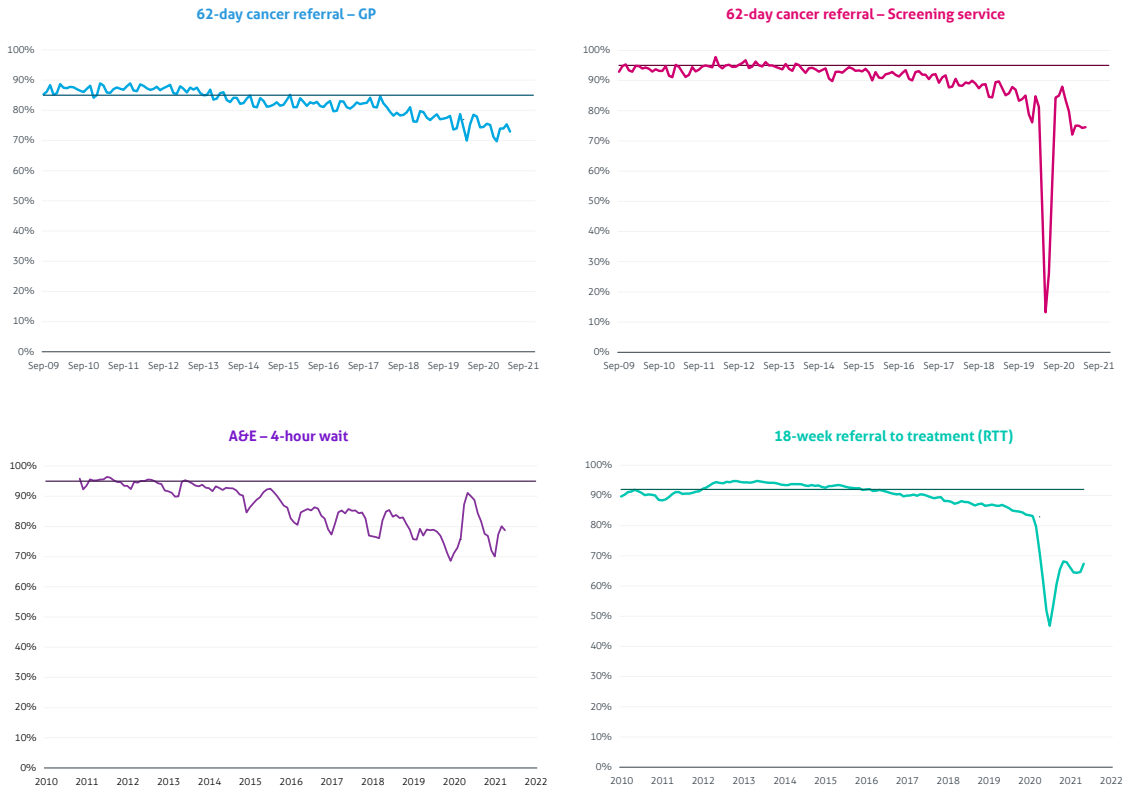
The nature of the backlog is reflected in how waiting lists have grown over the past year. Hospitals always have more patients than they can handle immediately, and waiting lists are a form of rolling backlog. For many key services, such as treatment pathways or diagnostic tests, the size of these waiting lists has been growing slowly but steadily over time. When the pandemic began, the overall size of the wait lists dropped – though this was mostly due to the sudden drop-off in referrals as far fewer people attended GP appointments and outpatient clinics. This was compounded by GPs – being mindful of pressures on hospitals – referring patients at a lower rate (see GPs chapter for more).

While the overall size of the waiting lists fell, the length of time people were on the list shot up. The number of people waiting 18 weeks or more to begin treatment has been rising slowly over time, but the pandemic pushed it to unprecedented highs. And while hospitals managed to bring this back down somewhat over the summer of 2020, it rose again during the second wave of the pandemic. A similar trend is seen in the wait times for diagnostic tests.

Put simply, as the pandemic's two main waves receded demand for health care grew faster than hospitals' ability to provide treatment. As a result the waiting lists have grown.

Performance against targets declined during the pandemic

Figure 2.9 **NHS England – performance against key targets**



Source: NHS England, 'A&E Attendances and Emergency Admissions 2020-21', March 2021; NHS England, 'Monthly Diagnostic Waiting Times and Activity', June 2021; NHS England, 'Consultant-led Referral to Treatment Waiting Times Data 2020-21', June 2021.

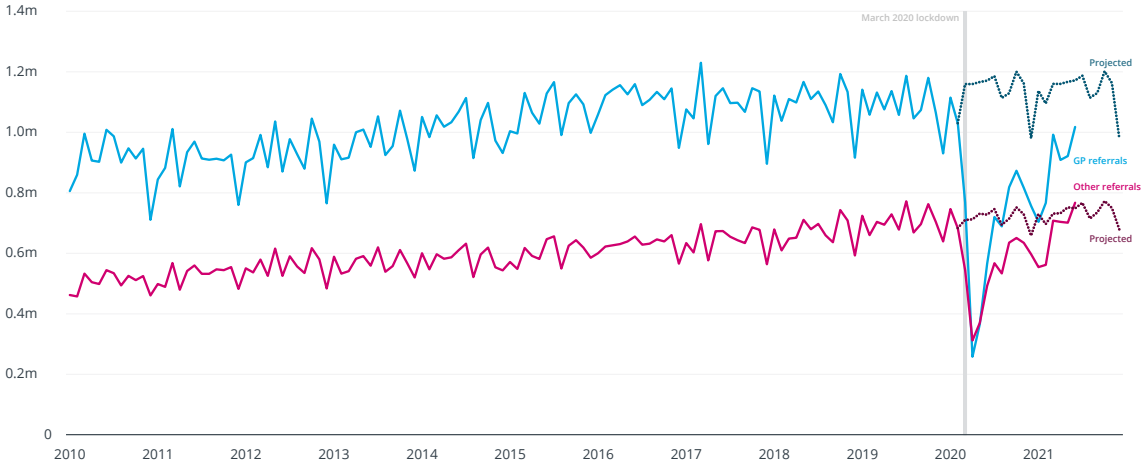
The NHS has a set of targets intended to drive up the performance of key services,[85,86] including ones that focus on reducing waiting times. Some of the most important are:

- At least 95% of patients are admitted, transferred or discharged within four hours of arriving at an A&E department
- At least 92% of patients receiving elective treatment within 18 weeks of a consultant-led referral
- At least 90% of patients receiving their first treatment for cancer within 62 days of an urgent referral from a screening service
- At least 85% of patients receiving their first treatment for cancer within 62 days of an urgent GP referral.

NHS trusts in England have missed all four of these targets for years, and the long-term trend has been one of slow, steady declines in performance.[87,88,89] The widespread disruption of routine health care during the pandemic led to dramatic declines in performance against most of these indicators.[90] Cancer treatment following screening and (other) treatments following referral by a consultant were hit hardest. While performance rebounded over the late summer of 2020, it fell off again during the second wave, and is currently not only far off the target, but even further off the pre-pandemic trend.

Notably, the waiting times for cancer treatment following a GP referral were largely unaffected by the pandemic, although the overall performance has declined in line with the prior trend. While the total number of referrals from both GPs and screening services dropped at the start of the pandemic, those who were referred were processed at a similar rate as before the pandemic. In March 2020 the number of GP referrals was almost 20% lower than a year before, almost 40% lower in April, and wouldn't recover until August. Screening services saw a far bigger drop, falling more than 80% relative to the year before in June 2020.

Figure 2.10 **Referrals to acute care**



Source: NHS England, 'Monthly Outpatient Referrals Data', July 2021.

Overall GP referrals fell far more than referrals from other sources – to the extent that other referrals represented a majority in April and May 2020 for the first time.* While some of this is explained by fewer GP appointments taking place, it also follows GPs referring fewer of the patients they saw to treatment than before the pandemic.

A&E performance is probably the NHS's most high-profile target, often making the headlines and being used in party political campaigns. During the first lockdown, A&Es saw an early surge (including many severe cases of Covid) followed by a sudden drop-off as people followed government advice to avoid putting pressure on the NHS (and potentially were doing fewer risky activities that might land them in A&E because of the lockdown – fewer people on the roads, little to no sporting activity, and pubs and clubs were closed).[91,92,93] However even with fewer people coming in, they were still unable to hit the 95% target. Much of this was due to redeployment of A&E staff and limited bed capacity, though the type of cases coming in was also a factor, with far fewer easily resolved cases and the majority of patients requiring urgent hospital admission and a bed.

The sharp decline in performance during the pandemic was caused by the widespread disruption of routine health care – but performance had in most cases been slipping before the pandemic. The government will need to focus on both the amount of NHS funding, how it is allocated and how it is used if it wants hospitals to return to meeting key targets.

Hospital capacity remains constrained

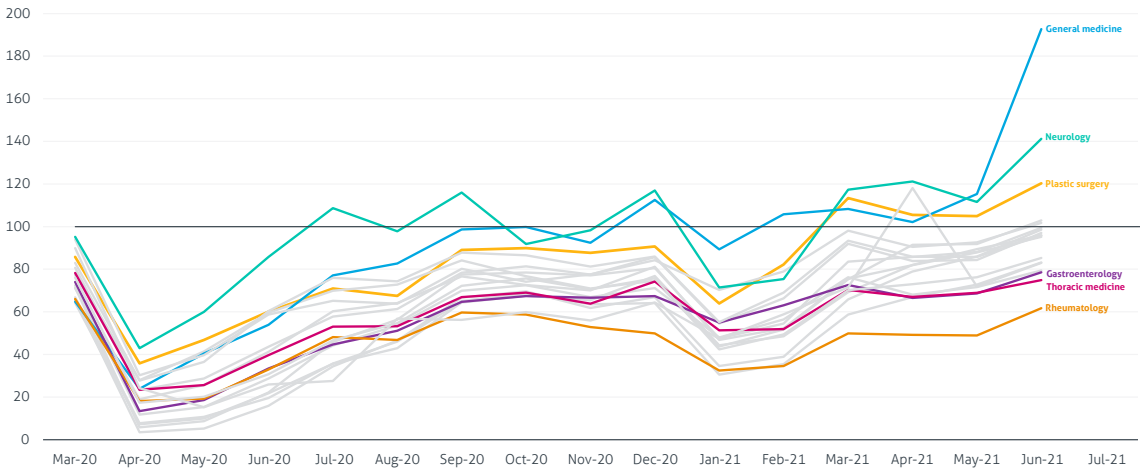
All forms of inpatient care slowed down at the start of the pandemic, as resources were redirected to manage coronavirus cases. Over time the various specialities have recovered, and some are now managing more treatment pathways than projected, based on pre-pandemic trends. This will help to clear some of the backlogs that have built up over the past 18 months. This activity has been supported by at least £1bn in additional funding that the government announced in September.[94]

However, most treatment areas are still underperforming relative to pre-pandemic trends, as shown in Figure 2.11. Most notable are rheumatology (61.7% of projected activity), thoracic medicine (74.9%), gastroenterology (78.6%), general surgery (79.4%) and geriatric medicine (82.9%).[95]

The number of diagnostic tests that hospitals perform has also recovered slowly from its low point during the first wave of the pandemic and subsequent dip during the second wave. While some procedures have recovered to their projected pre-pandemic levels, most services are still limited.

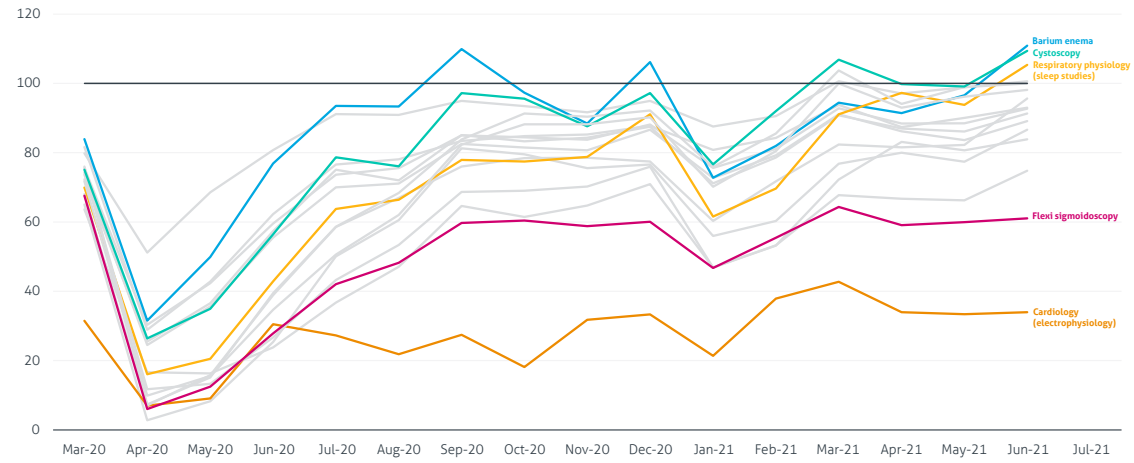
* Other referrals include those made by consultants in A&E departments or outpatients, prosthetists, specialist nurses, allied health professionals, optometrists, orthoptists or a national screening programme.

Figure 2.11 **Admitted treatment pathways: actual activity relative to projected activity**



Source: NHS England, 'Consultant-led Referral to Treatment Waiting Times', July 2021. The relative activity is calculated as a ratio of actual procedures and the projected number of admitted pathways had there been no pandemic, using the trend from January 2016 to February 2020.

Figure 2.12 **Hospital diagnostics: actual activity relative to projected activity**

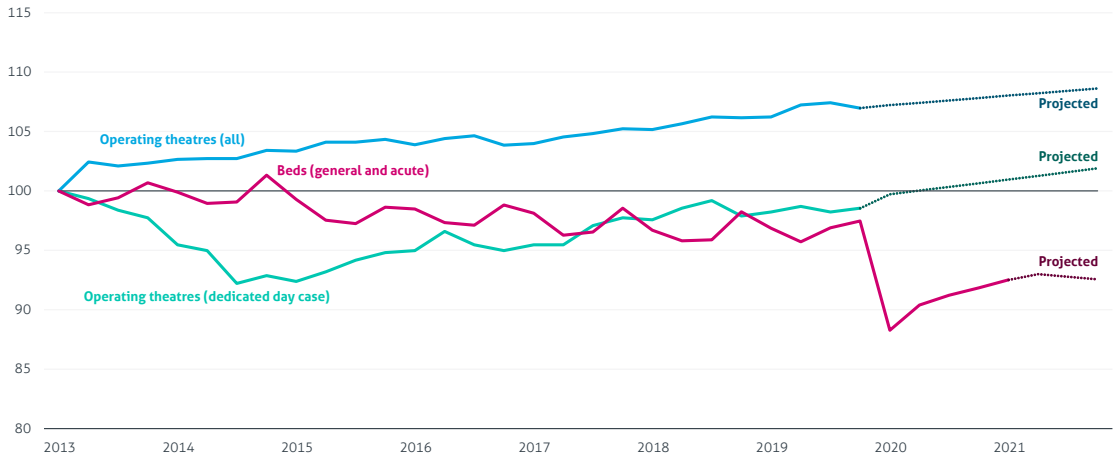


Source: NHS England, 'Monthly Diagnostic Waiting Times and Activity', June 2021. The relative activity is calculated as a ratio of actual procedures and the projected number of diagnostic procedures had there been no pandemic, using the trend from January 2016 to February 2020.

The types of treatments and tests that are most constrained are those where there is a heightened risk of transmission. In particular, procedures that generate aerosols (such as spirometry, used to diagnose asthma and COPD)[96] and thoracic medicine (relating to the respiratory system) have been difficult to administer safely, and so add to the backlog.

New constraints – as well as old ones – will limit hospitals' ability to clear the backlog

Figure 2.13 **Hospital capacity – beds and operating theatres (Q1 2013 baseline)**



Source: NHS England, 'Bed Availability and Occupancy Data – Overnight', 19 August 2021; NHS England, 'Supporting Facilities Data'.

Hospitals have been undergoing a long-term transformation of their capacity to admit and treat patients. The number of beds in acute trusts has decreased steadily since 2013 as hospitals found effective ways to treat more patients as either day cases or without requiring admission.[97] This trend is also reflected in the relatively flat number of admitted treatment pathways – despite increasing demand for hospital services.[98]

Bed numbers are seasonal, more being added every winter to manage the expected increase in demand. The number of beds available in general and acute trusts fell sharply shortly before the pandemic, decreasing by around 9,500 between the fourth quarter of 2019 and the first quarter of 2020,[99] before more were added throughout 2020 and 2021 to manage the surge in critical cases.*

We expect that hospitals will revert to the longer-term trend of reducing bed capacity, but will need the additional capacity to help clear the backlog before they can do so. Adding to the pressure is the move by hospitals to reduce bed density on some wards to help prevent the spread of Covid. This, as noted, has a ripple effect, as reduced bed capacity places constraints on other parts of the health care system – such as the ability of A&E departments to admit patients in a timely manner.

Theatre capacity is another constraint. While the NHS has been steadily increasing the number of operating theatres – including those dedicated for day cases – it seems unlikely that hospitals will be able to fully utilise them at pre-pandemic levels due to increased infection control requirements. NHS guidance advises that procedures in the low-risk Covid pathway do not require additional cleaning or downtime between procedures, but many procedures fall outside this category.

* This number does not include the capacity added as part of the Nightingale hospital programme.

These novel requirements to clean and ventilate operating theatres may persist into the foreseeable future and will limit hospitals' ability to both return to pre-pandemic service levels and clear the backlog of cases.

There are other constraints that limit hospitals' ability to simply scale up treatment. Shortages of qualified staff are a real problem; in particular, there are not enough anaesthetists and perioperative nurses to meet the demand for surgical treatments.[100,101] Other risks are even harder to predict, or manage. Ongoing issues with supply chains across the UK (and much of Europe) have driven up prices or led to shortages for many goods, including CO_2, gas, petrol and medical supplies, such as ICU consumables, gloves and blood tubes. These shortages affect both the operating costs for hospitals and have slowed down testing and treatment.[102,103,104]

The pandemic drove innovations that may offer long-term benefits

The number of face-to-face outpatient appointments grew at an average rate of more than 4% annually between 2009/10 and 2019/20.[105] This was viewed as unsustainable without faster growth in NHS spending and the 2019 NHS Long Term Plan laid out approaches to reduce the number of face-to-face appointments by a third. This was expected to save the NHS more than £1bn a year,[106] with virtual consultations seen as key to achieving this.[107] The requirements of social distancing accelerated this, and it seems likely that the shift will be permanent, at least to some degree.[108,109]

As of yet there have been few evaluations of remote outpatient appointments, but early indications suggest that they are at least acceptable to patients and clinicians – although impacts on patient outcomes are as yet unknown.[110,111,112]

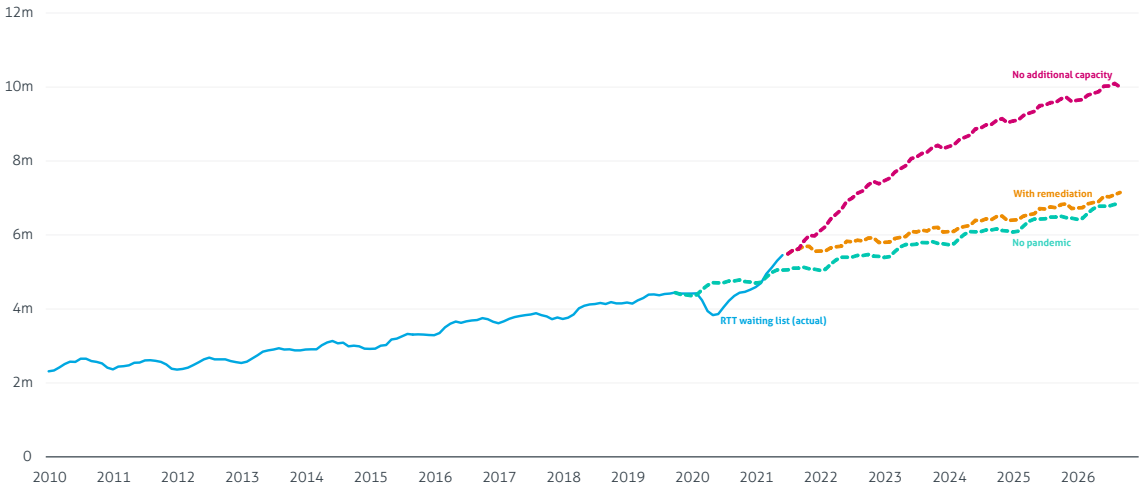
How will demand for hospitals change?

Demand for health care will continue to rise in the foreseeable future. Underlying demographic change – in particular, the growing share of the population that is elderly, living with multiple long-term health conditions, or both – is the main cause of this. There are also additional, novel pressures on hospitals arising from care needs not met during the crisis. Hospitals have limited options to meet this demand. Existing constraints, such as the availability of inpatient facilities to diagnose and treat conditions, and the staff to administer those services, are hard to scale up in short order. Novel requirements, such as enhanced infection control regimes, create a headwind for the number of procedures hospitals can conduct.

More money will go only so far to solving this problem. Staff take time to train and the global nature of the Covid crisis creates correlated demand across developed nations, creating competition for the NHS if it tried to recruit from overseas. Similarly, new facilities take time to build, although the NHS has scope to make use of independent sector providers to add capacity there – at a cost.

Waiting lists for treatments and diagnostic tests were rising before the pandemic. The crisis has driven them higher. And there is a further, as yet unrealised tranche of new cases waiting to come through the system as a result of backlogs in primary care. Just taking hospital treatments, we project that in the absence of any new financial support to create additional capacity waiting lists will rise to more than 10 million by 2026 – comparable to other estimates.[113,114] Remediation, which would keep waiting list growth comparable to the pre-pandemic trend, would cost around £7bn on average per year over the next five years. Getting to a point where waiting lists actually begin to fall would require even higher levels of additional funding.

Figure 2.14 **Historical and projected size of referral to treatment (RTT) waiting lists**



Source: Institute for Government health system model.

There is scope for the NHS to deliver efficiencies to help mitigate these costs to an extent. There are at least early signs that a shift to remote outpatient appointments could save money and potentially improve services. Ongoing efforts to route patients more effectively and minimise the number of people requiring inpatient care could also be extended, helping manage caseloads.

But the legacy of the pandemic could also increase costs above the levels outlined here. For example, long Covid is poorly understood but could increase costs should it go on to mean sufferers require continued health care. Similarly, if coronavirus remains as an endemic, seasonal infection, it will become a new burden on the NHS that it will have to manage in perpetuity – even if vaccination rates among the population remain high. For hospitals this would take the form of additional inpatient care, and a permanently heightened infection control regime, which also creates wider capacity constraints within hospitals.

The NHS has set out an £8.1bn Plan for Recovery as part of its annual Operational and Contractual Planning Guidance for 2021/22.[115,116] However, this covers only the coming year and may be overly optimistic about the pressures that staff face. The £5.4bn package announced in September 2021 provides some support to see the NHS through a (potentially) challenging winter.[117]

Confusingly, these funds are intended to support social care over the next three years, but will go towards NHS recovery first.[118] Further funding is dependent on the outcome of the spending review.

As of June 2021 NHS England was still in planning stages for how it will reduce the backlog, with a board report noting that it was prioritising "a series of reform initiatives covering demand management, pathway improvement, diagnostics, outpatients and independent sector usage" and that "work is ongoing to agree the levels of ambition and to model the impact that these initiatives can have on the waiting list".[119] However, NHS Providers is concerned that another winter surge could disrupt any plans for stabilisation and recovery. It is also sceptical that the use of activity-based targets in the elective recovery fund is a good form of incentive – and may be actively hampering the recovery.[120,121]

The government's main priority for hospitals should be to provide sufficient funding to allow trusts to recover from what has been the greatest shock to the system in the post-war period. Enabling hospitals to keep on top of the growing demand for care while also addressing record backlogs will be expensive – far eclipsing the amounts forecast in the NHS 2019 Long Term Plan.

3. Adult social care

Adult social care has been hit hard by the pandemic. Local authorities have not been able to provide the full range of services they would normally. Care providers have struggled to keep social care users safe during the pandemic and measures to protect those in care homes have often meant families and friends could not visit. Tragically, there were more than 27,000 excess deaths in care homes in 2020/21,[1] partly due to the government's early decision to discharge residents from hospitals back to care homes without testing.

The government has announced that it will reform adult social care by expanding eligibility for, and capping the costs of, publicly funded care. This will require additional public spending, while demand for the existing means-tested and needs-tested system will continue to rise quickly as well. We project that public spending on adult social care would have to increase by at least 9.7% between 2019/20 and 2024/25 to provide care to the growing number of people eligible for publicly funded care in the current system. Given the lack of data available to monitor the impact of the pandemic on adult social care, the government should prioritise collecting data on waiting times and unmet need, to help it understand how many people who could not access care during the crisis now require additional help.

This chapter focuses on publicly funded adult social care in England: the provision of support and personal care (as opposed to treatment) to meet needs arising from illness, disability or old age. The vast majority of care, however, is provided voluntarily, typically by family and friends, and some people pay for their own care* – this chapter discusses only these types of care in the context of publicly funded care.

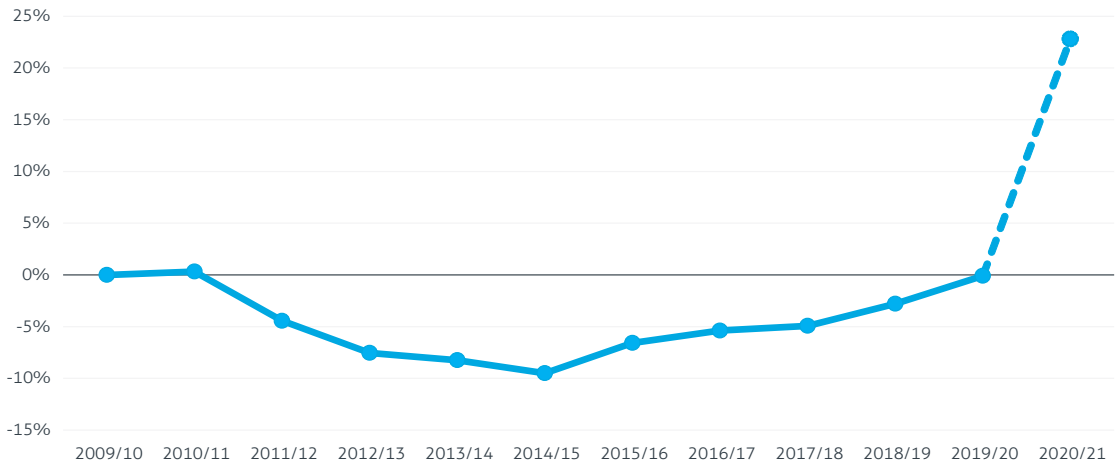
In England, publicly funded care is mostly arranged by local authorities, who have a legal duty to fund care for those whose needs meet the national eligibility criteria, as set out in section 13 of the 2014 Care Act, and who pass a financial assessment (means test). These services are often delivered by the private and charitable sectors, although some local authorities also provide care services directly themselves. Adult social care is delivered and mainly funded locally, but decisions by central government shape how much money local authorities have to do this, as well as what they are obliged to spend it on – making adult social care a national as well as a local responsibility.

* The National Audit Office (NAO) estimates that most social care is unpaid and provided by friends and family, equating to £62–£103 billion, followed by publicly funded care (£22bn) and self-funded care (£11bn), National Audit Office, *Adult social care at a glance*, 2018, p. 10, www.nao.org.uk/report/adult-social-care-at-a-glance

Public spending on adult social care rose to support care providers during the pandemic

Public spending on adult social care had started to rise rapidly before the pandemic, although even in 2019/20 it was still lower than in 2009/10. By the time the pandemic hit, public spending on social care had returned to the level it had been before the onset of large central government cuts in grants to local government in the 2010s.

Figure 3.1 **Change in public spending on adult social care in England (real terms) since 2009/10**



Source: Institute for Government analysis of NHS Digital, *Adult Social Care Activity and Finance Report, England 2019–20*, Appendix B, Table 4; MHCLG, 'Local authority revenue expenditure and financing England; 2019/20 and 2020/21 individual local authority budget data'.

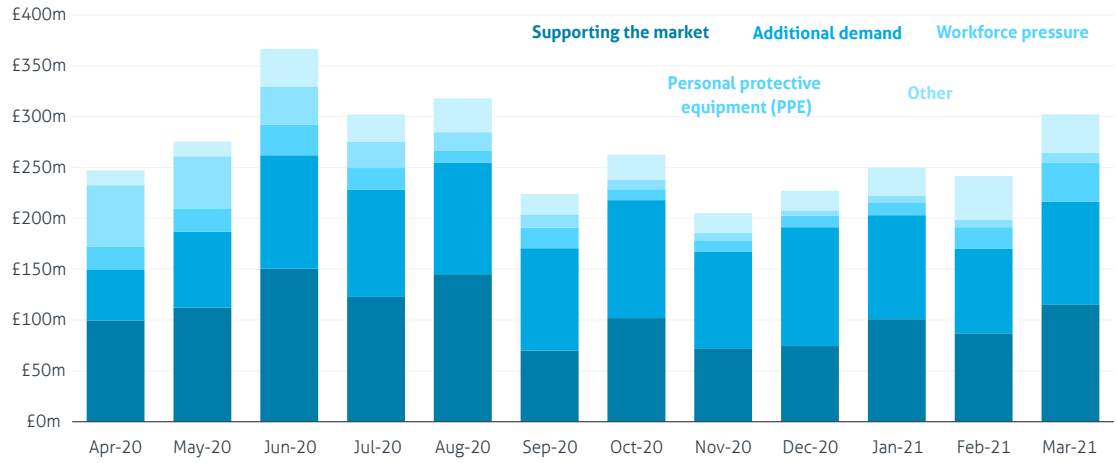
The pandemic led to huge increases in spending on adult social care. In 2020/21, local authorities spent £3.2bn on adult social care in response to coronavirus (see below); 18% of what they had originally budgeted before the pandemic.[2] If public spending on adult social care changes in line with local authority spending on adult social care, which makes up the vast majority of this spending (88% in 2019/20[3]), then we estimate that public spending will have been between 17% and 24% higher in 2020/21 than it was in 2019/20.*

Local authorities funded this extra spending through repeated grants from central government, which were designed to cover the extra direct and indirect costs of the pandemic, from additional personal protective equipment (PPE) to breakdowns in unpaid care where vulnerable people were unable to get as much help from family and friends as they normally would. Some funding, such as through the Infection Control Fund[4] and the Rapid Testing Fund[5], was provided to local authorities to distribute with limited discretion. Local authorities administered these funds to care providers on behalf of central government. For other grants, such as the emergency grant funding at the start of the pandemic,[6] local authorities had discretion over how to allocate the money, and whether to allocate it to adult social care or other local services.

* We estimated this by assuming all local authority adult social care spending reported in the Ministry of Housing, Communities and Local Government (MHCLG) local authority Covid financial impact monitoring information was additional. We then calculated the change in budgeted local authority spending on adult social care in 2019/20 and 2020/21, including additional Covid spending in 2020/21. To derive an estimate of public spending on adult social care in 2020/21, we multiplied the change in budgeted spending to the NHS Digital estimate of public spending on adult social care in 2019/20.

Local authorities spent these grants to combat a variety of pressures. In the initial months of the pandemic, local authorities' most frequent use of additional funding was to 'support the market' by covering care providers' temporary higher costs, such as higher staffing and lost income from lower occupancy.[7] Local authorities did this by, among other things, paying providers in advance rather than arrears, and paying providers for services that were not delivered as a result of the pandemic.[8] After September 2020, the most frequent use of additional funding was 'meeting additional demand' – in other words, using the money to provide support to people whose needs had become more complex during the pandemic and people who had newly requested support during the pandemic.

Figure 3.2 **Additional local authority spending on adult social care in 2020/21**



Source: Institute for Government analysis of MHCLG, 'Local authority COVID-19 financial impact monitoring information', R12.

The additional funding had some successes. Fewer care providers closed in 2020 than in 2019,[9] despite initial fears.[10] The Covid grants helped prevent closures, but providers and local authorities are unsure how long infection control procedures will continue, how and whether demand for care services will recover, and how much money central government will provide in future. Consequently, the care provider market remains unstable, as it had been before the pandemic. The proportion of local authority directors of adult social care who are worried about the financial sustainability of their residential and nursing providers increased from 66% in 2020/21 to 77% in the current financial year.[11]

While local authorities did manage to prevent most care homes from going bust, most struggled to commission care packages during the pandemic. Owing to pandemic restrictions, many local authorities temporarily closed respite services such as day centres,[12] and during the first six months of the crisis, there were reductions in the amount of publicly funded care because of difficulties of providing care in a Covid-compliant way.

More worryingly, some local authorities cut social care services during the pandemic owing to wider financial pressures. While the UK government covered much of local authorities' lost revenue and cost pressures in 2020/21 in aggregate, some local authorities faced shortfalls. The Institute for Fiscal Studies estimates that 233 (69%) English local authorities did not receive enough money to cover the financial shortfalls created by the pandemic in 2020/21 – meaning they had to either draw down reserves or make in-year savings.[*,13] In some cases, those savings came from adult social care. When surveyed in November 2020, 13% of local authority adult social care directors said that they had to find in-year savings beyond those planned before the pandemic[14] and only 23% of directors were confident that they could meet their statutory social care duties within the current financial year.[15] When surveyed again in May 2021, only 21% of directors were fully confident that planned savings would be fully met in 2021/22, and that they would meet their statutory duties in 2021/22.[16]

Care worker vacancies temporarily fell during the pandemic

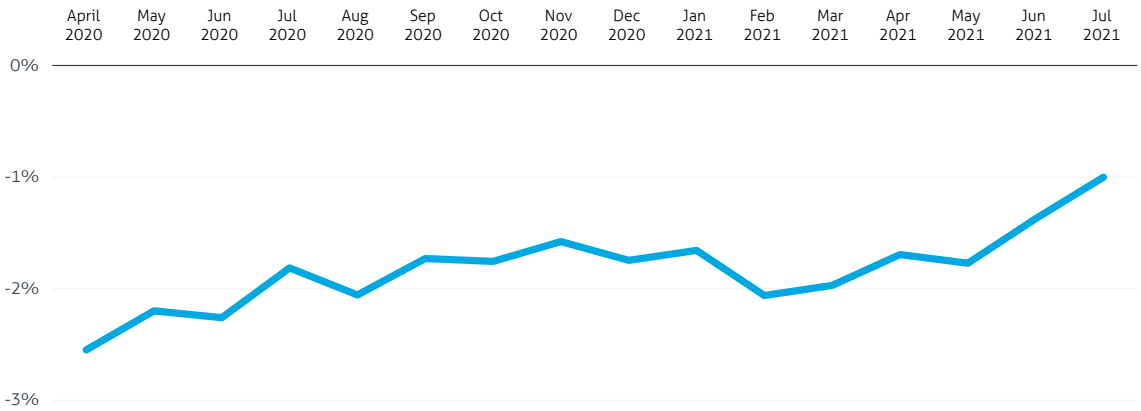
The social care workforce was strained before the pandemic, with 112,000 vacancies[17] and 7% of positions being unfilled in 2019/20. However, the adult social care workforce grew during the pandemic. The number of people working in adult social care increased by 3% between 2019/20 and 2020/21, from 1.63m to 1.67m,[18] the fastest rate of growth since 2012/13. Most of these new staff worked in community care services (care provided in people's homes), which may reflect a shift in people preferring care at home to residential care.

This growth in the workforce initially reduced reported vacancies. Vacancies fell at the start of the pandemic as more people joined care work, most likely due to job opportunities drying up in other sectors. In March 2020, after the imposition of the first nationwide lockdown, care providers reported an increase in job applications,[19] and by April 2020 the vacancy rate was 2.6 percentage points below the vacancy rate in March 2020. Some of this is attributable to government action to increase care worker recruitment in light of the need for more staff. During the first and second coronavirus waves, the UK government initiated national recruitment campaigns (in April 2020[20] and February 2021[21]), although it is hard to pinpoint the impact of these campaigns.

However, this improvement in recruitment has not kept pace with the growth in vacancies in the second half of 2020 and the vacancy rate has crept closer to its pre-pandemic level over time. The vacancy rate was just 1.4 percentage points below its pre-pandemic level by June 2021. In home care, the vacancy rate was slightly higher in June 2021 than it was in March 2020.[22]

* Local authorities cannot borrow to finance day-to-day spending, and therefore cannot run deficits. Atkins G, Davies N, Wilkinson F and others, 'Local authority financial sustainability', in *Performance Tracker 2019: A data-driven analysis of the performance of public services*, Institute for Government, 2019, www.instituteforgovernment.org.uk/publication/performance-tracker-2019/local-authority-financial-sustainability

Figure 3.3 **Percentage point difference between adult social care vacancy rate in March 2020 and each subsequent month**



Source: Institute for Government analysis of Skills for Care, 'Monitoring the impact of COVID-19 – Vacancy rate'. Vacancy rate calculated based on a sample of care providers that updated their workforce data each month

Staffing difficulties are likely to get worse over the winter. Staff burnout from the Covid response, combined with the government's post-Brexit immigration system,* mean that there is a real risk that there will not be enough social care staff to provide care to all those eligible for and in need of publicly funded care this winter. Vacancy rates rose during the summer, from 6.2% to 8.2% between April 2021 and August 2021.[23] The Department of Health and Social Care (DHSC) has publicly reported data on the proportion of providers saying that they were at risk of breaching, or had breached, their 'agreed staffing ratios' – the safe number of residents for any given member of staff that individual providers determine with their staff[24] – since December 2020.[25]

The proportion of providers reporting breaches has steadily risen each week since the week ending 1 June 2021 and, in the week ending 24 August, 3.6% of providers said staffing ratios were a risk – although that remains below the 4.6% who reported staffing ratios being a risk in the week ending 19 January 2021. When surveyed in August 2021, 78% of home care providers said recruitment was "the hardest it has ever been" and 30% reported they had handed back some, or all, of their care contracts to local authorities because they did not have the staff to fulfil them.[26] The introduction of a new requirement that care home workers have to be vaccinated against Covid by 11 November 2021[27] is likely to further increase vacancies and increase recruitment costs for care homes (the DHSC estimates by 40,000 and £100m respectively[28]).

* The new migration system has made it harder for providers to recruit care workers from European Economic Area countries because only qualified social workers are eligible to use the fast-track visa route. Holmes J, *Brexit and the End of the Transition Period: What does it mean for the health and care system?*, The King's Fund, January 2021, www.kingsfund.org.uk/publications/articles/brexit-end-of-transition-period-impact-health-care-system

This growth in vacancies was both predictable and predicted.[29] Care providers told a DHSC taskforce that they had been able to staff homes safely during the first wave only because "partners of care workers were either furloughed or unemployed, enabling existing staff to work longer hours". In October 2020, care providers worried that "as economic activity picks up, the conditions that have led to high vacancy levels and 40% turnover of care staff will reapply".[30]

They have been proved right. The vacancy rate has steadily increased as employment in sectors where entry-level care workers also tend to go, such as retail and supermarkets, has started to recover. The well-publicised difficulties of working in social care during the pandemic – from the high Covid death rates[31] to the stressful working environment[32] – may have put people off applying. The experience of the pandemic may also feed through to lower retention rates later, although there is as yet little evidence on how the pandemic will affect staff retention.

The government will need to take further action if it wants to stop vacancies rising in the medium and long term. The DHSC's social care taskforce recommended a loyalty bonus for those who remain in post for a specified period of time. The Commons Health and Social Care committee[33] and the Association of Directors of Adult Social Services (ADASS)[34] called for a long-term workforce plan akin to the NHS – although the government has not implemented either.[35]

The pandemic disrupted the provision of publicly funded social care

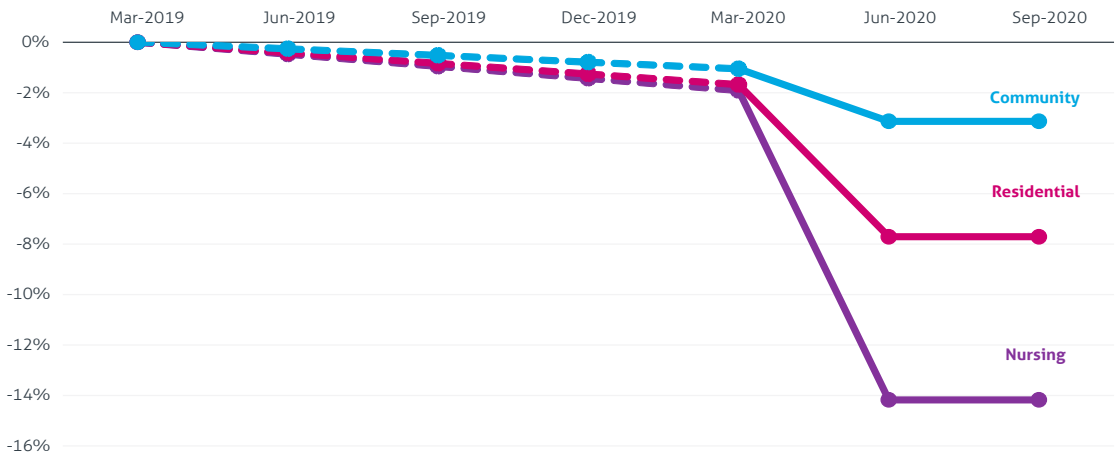
Local authorities were not able to provide care to as many people as normal. Fewer people started to receive care, and care services were pared back for those already using services.

The number of people receiving publicly funded long-term care during the pandemic fell by 4% between 31 March 2020 and 30 June 2020. This initial drop tapered off after the first wave, and the number of people receiving this kind of care increased by 1% between 30 June and 30 September. This was solely due to an increase in the number of people receiving community care packages – the number of people receiving nursing and residential care continued to fall.

The reduction in the number of people receiving publicly funded long-term care accelerated pre-Covid trends, albeit for very different reasons. Before the pandemic, the number of people receiving this kind of care had declined slowly, by 4.4% between 2014/15 and 2019/20. Local authorities had partly made up for this by increasing the amount of short-term 'reablement' care they provided, such as advice, training or equipment to support people to live independently.[36,*]

* NHS Digital did not ask local authorities to collect data on short-term care provided in its 2020/21 management information, so we do not know whether the number of people who received short-term care increased during the pandemic.

Figure 3.4 **Change in the number of people receiving long-term state-funded care packages since March 2019**



Source: Institute for Government analysis of NHS Digital, Mid-Year 2020-21 Adult Social Care Activity, SALT Table 38 Q1 and Q2; NHS Digital, Mid-Year 2020-21 Adult Social Care Activity: Previous Years' Comparative Data Tables, SALT Table 38 18-19 and 19-20. * = Values for June 2019, September 2019, and December 2019 are linear interpolations because NHS Digital did not collect data on the number of people receiving long-term state-funded care in these months.

In contrast, the high rate of deaths in care homes[37] during the pandemic rapidly reduced the number of people receiving publicly funded residential and nursing care between March and June 2020. Care home occupancy fell from 85–87% in February 2020 to just 75–80% in May 2021.[38,*] Low care home occupancy is likely to persist if people remain less likely to seek residential care as a result of the pandemic. Polling conducted in May 2020[39] found that 31% of people were a bit or much less likely to seek residential care for an elderly relative than before coronavirus. Likewise, 40% of people aged 65 or over were a bit or much less likely to seek residential care for themselves than before coronavirus, although there is not specific data on likelihood to seek community services.

The small reduction in the number of adults receiving community services – care that takes place within people's own homes such as home care, day care and meals-on-wheels – between March 2020 and September 2020 is more complex and reflects at least four factors.

First, some people may not have requested care due to concerns about coronavirus. Second, some services closed owing to the difficulty of providing services in a Covid-safe way. ADASS estimates that local authorities had the capacity to provide day centre services to 42,099 people in October 2020 – a 47% decline compared to February 2020.[40] Third, even where people sought care and local authorities thought they could commission it in a Covid-safe way, private providers in some cases struggled to provide those services. Because of restrictions they put in place to contain the spread of the virus – such as limiting the number of people each care worker was allowed to see, and recruiting and training new care workers remotely – they did not always have the ability to provide care.[41]

* The different figures represent care homes with nursing and care homes without nursing, respectively.

Fourth, eight local authorities used the emergency Care Act easements, which during crises remove certain statutory requirements to provide fewer services – although this mainly consisted of delaying and shortening care assessments, rather than providing fewer community services.[42]

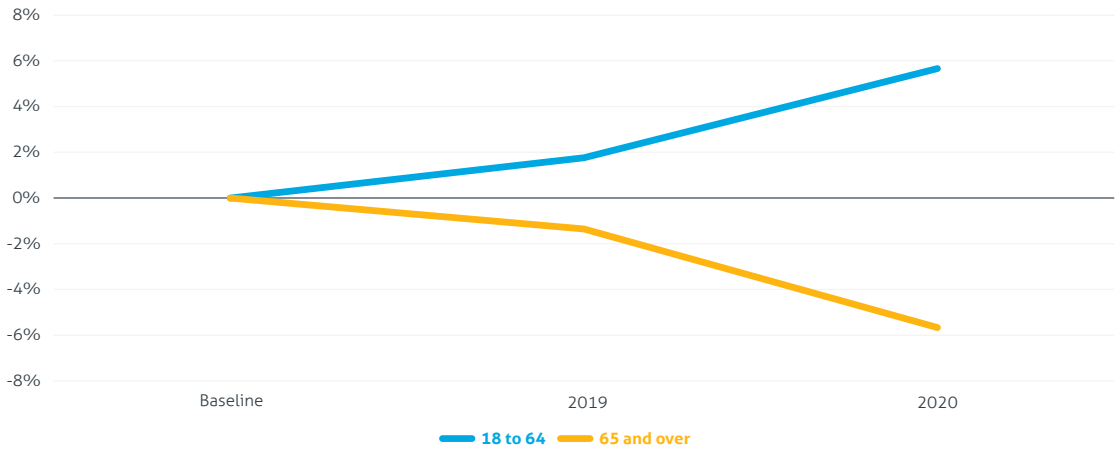
The picture in the second half of 2020/21 is less clear. There is as yet little information to judge the provision of care during the second and third England-wide lockdowns.* One indicator that is available – reports from local authority social care directors on capacity for day centre and home-based respite support – suggests there was greater capacity in April 2021 compared to October 2020,[43] although this is still below the pre-pandemic levels in February 2020.

Despite a lack of data on the second wave, there was a large fall in publicly funded care provided throughout the first wave of the pandemic. If the government wants to maintain the supply of care at pre-pandemic levels, it will have to continue providing support to care providers to avoid the current reductions in demand translating into permanent closures.[44] In February 2021, average occupancy levels in care homes were still only around 80%; compared to around 90% at the start of the pandemic.[45]

Many people struggled to access social care during the first wave

The fall in publicly funded care does not reflect a fall in the need for care, although the picture is complex. Local authorities received fewer requests for support at the start of the pandemic, driven by a 4% decline in requests from people aged 65 or older. In contrast, requests for support from people aged 18–64 rose, continuing the pre-pandemic trend.[46]

Figure 3.5 **Change in requests for support from new clients versus baseline (1 April – 30 September 2018)***



Source: Institute for Government analysis of NHS Digital, 'Mid-year 2020–21 adult social care activity', SALT Table 8; NHS Digital, Mid-Year 2020-21 Adult Social Care Activity: Previous Years' Comparative Data Tables, SALT Table 8 18-19 and 19-20. * = 2020 figure relates to the period 1 April - 30 September 2020. New client requests for support in baseline and 2019 are calculated as half of the 2018/19 and 2019/20 years, and so are not directly comparable to 2020 figures.

* NHS Digital publishes data on publicly funded social care activity. The 2020/21 statistics are due to be published on 21 October 2021, NHS Digital, 'Adult social care finance return', https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-collection-materials-2021#adult-social-care-finance-return-asc-fr-

On the surface, this suggests that there was less need during the pandemic – but referrals are not always a good indicator of need. Some people in need do not contact local authorities, and so there may be some unmet need. The English Longitudinal Survey of Ageing, which captures the behaviour and needs of those who do not contact services as well as those who do, found that some people who needed care went without it during the pandemic. Only one quarter of those aged 50 and over who needed community services between February and May 2020 actually received such care.[47,*] People who did not receive care were evenly split between those who did not seek care and those who were unable to access it.

Unfortunately, there is no directly comparable data on unmet need before and after the pandemic – but unmet need almost certainly increased during the pandemic with the reduction in publicly funded social care. Many people struggled to access care. The Care and Support Alliance found that only a fifth of people who asked their council for care during the pandemic received increased care – although the survey was based on a self-selecting set of people who needed social care and was not weighted to be nationally representative.[48]

While they were unable to provide care normally, local authorities sought other ways to support adults. Most local authority directors of adult social care said that they had managed the increase in people presenting with needs by providing more advice and information than normal.[49] Of the requests for support local authorities received between 31 March 2020 and 30 September 2020, 58% resulted in either the local authority signposting requests to other services or not providing services, compared to 55% during 2019/20.

In addition to reductions in social care provision, people already in receipt of social care also found it harder to access health services during the pandemic.[50] There were 36% fewer non-Covid emergency admissions and 63% fewer elective care admissions from care home residents when comparing 1 March to 31 May 2020 to the same period in 2019.[51] Inability to access health care may have resulted in rising numbers of people requesting social care. Almost half of local authority directors of adult social care said that there had been an increase in people being referred to adult social care as a result of people not being admitted to hospital.[52]

Reduced access to health and social care services during the pandemic will have lasting consequences for users and their carers' health and wellbeing.[53] As a result of not receiving local authority care, over a third of adults who were in need of social care said they felt lonely and just over 10% said that they had been unable to work.[54] Another study of people living with dementia, and their unpaid carers, found that both reported lower wellbeing and higher prevalence of depression symptoms when comparing their responses six and 12 weeks after the start of the first lockdown in March 2020.[55]

* 42% of participants reported requiring community services, but only 11% of participants reported receiving such services.

The most likely consequences of the reduction in publicly funded care are rises in unmet need – people who should be receiving care but are not – and unpaid care.* Nearly a quarter of local authority adult social care directors said there had been a rise in unmet need between March 2020 and May 2020.[56] Unfortunately, we have little information on the extent of unmet need after the first coronavirus wave because the

2020 Health Survey for England,[57] which normally records the extent of help needed among people aged over 65, was cancelled. The 2021 Health Survey for England will provide information on whether unmet need is higher after the pandemic than before – but it will not tell us about how unmet need changed during the pandemic.

The clearest consequence is that unpaid care provided by family and friends rose. A Health Foundation analysis of longitudinal survey data from Understanding Society found that 32% of the English population were providing unpaid care between November 2020 and January 2021, up from 17% in the last pre-pandemic survey (2018/19).[58] Two thirds of people providing care between November 2020 and January 2021 had not previously been providing care. This backs up a May 2020 survey of people in the UK, which estimated that 13.6 million adults were providing unpaid care in May 2020, and that 4.5 million had started providing care during the pandemic.[59] Those who were already providing care before the pandemic increased the support they provided. A September 2020 survey of carers by the charity Carers UK found that 81% of carers were providing more care than they did pre-pandemic.[60]

The rise in unpaid care will have wider economic and health consequences. Carers may leave the labour market to provide unpaid care, and their physical and mental health[61] may deteriorate as a result of caring.[62]

Many care home residents and people using care in their own homes died during the pandemic

Social care aims to improve the wellbeing of care recipients, but its impact is difficult to measure. Beyond safety, there are few good metrics to judge the quality of social care provided – or its effects on users' wellbeing. Most data that the public sector collects relates to the sheer volume of publicly funded care services provided.**

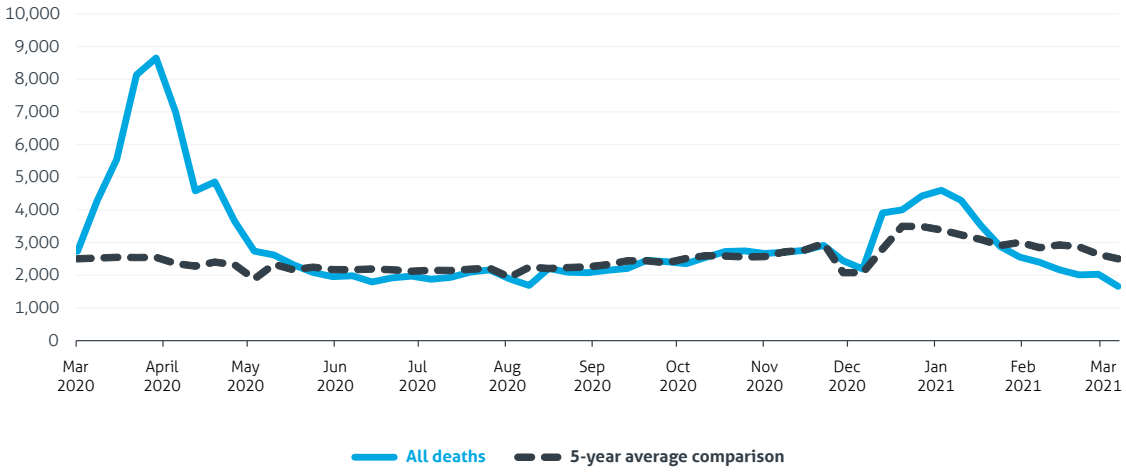
However, even on basic measures of safety – safeguarding and death rates – social care struggled during the pandemic. There were a large number of excess deaths in care homes at the start of the pandemic, following NHS England guidance to discharge all hospital patients medically fit to leave – with or without testing – on 19 March 2020, and the government's focus on protecting the NHS at the start of the pandemic.[63] While the proportion of Covid outbreaks in care homes that can be directly linked to hospital discharge is small,[64] at least some care home outbreaks were seeded through hospital discharge.[65]

* In normal times, people might also choose to replace publicly funded care with paying for their own care, but there is no evidence that this happened during the pandemic.

** There are two regular surveys of carers (Personal Social Services Survey of Adult Carers) and care users (Personal Social Services Adult Social Care Survey), but there is not yet data available on either carers or care users' views of care provided during the pandemic. The care users survey is due for publication on 21 October 2021; the carers survey did not run during the pandemic.

Just over 165,000 care home residents in England died between the week ending 20 March 2020 and the week ending 2 April 2021. This was 16% higher (or 27,000 more deaths) than the average for the same period over the preceding five years; this provides a rough estimate of how many people died as a result of the pandemic.*

Figure 3.6 **Number of care home resident deaths in England, by week of registration**



Source: Institute for Government analysis of Office for National Statistics, 'Deaths involving Covid-19 in the care sector, England and Wales', Table 1.

The causes of the high death rate are complicated and not all care home residents died directly from contracting Covid. Of the 28,627 excess deaths between the weeks ending 20 March and 19 June, 18,641 were classified as Covid deaths.** Joint analysis from the DHSC, Office for National Statistics and Government Actuary's Department suggests that changes made to adult social care to respond to the pandemic (such as reduced access to health care for non-Covid medical emergencies, and reductions in care support) contributed to at least some of the excess deaths in the first wave.[66]

Most of the excess deaths attributable to Covid occurred because care homes were not well equipped to cope with coronavirus; a problem made worse by government's decisions at the start of the pandemic. Residential care homes never expected to have to have facilities to isolate residents, as they are not intended to provide medical care; and few nursing care homes had the facilities to isolate residents after a decade of tight funding before the pandemic.[67] The slow roll-out of PPE to care home staff, limited access to testing, and lack of guidance caused further problems: the government did not publish a plan to manage coronavirus in adult social care until 15 April 2020.[68] As described above, many hospital patients were discharged to nursing and residential homes without testing or proper consideration of whether nursing homes had the staff or space to safely quarantine them.

* The excess death rate compared to the last five years in the second wave is a slight underestimate, due to the decline in care home occupancy during the pandemic and the change in care home demography, that is that there were fewer care home residents than the five-year average and those residents were, on average, healthier than care home residents before the pandemic, BBC Sounds, 'Covid deaths, outdoor swimming and care homes', 16 June 2021, www.bbc.co.uk/sounds/play/m000wz3z

** The number of care home resident deaths attributed to Covid in the first wave is likely to be an underestimate, however, given the limited availability of testing during the first wave.

People receiving home care were also hit hard.[69] The Health Foundation estimates that there were 2,726 excess deaths during the first wave (11 April to 19 June 2020) and 5,250 excess deaths during the second wave (5 September 2020 to 2 April 2021),[70] but excess death rates are hard to calculate given the rise in home care registrations with the Care Quality Commission in the years leading up to the pandemic.

There was also a large rise in safeguarding concerns during the pandemic – where a local authority is notified of an adult with care and support needs who is experiencing, or is at risk of, abuse and neglect.[71] Local authorities received 198,370 reports of safeguarding concerns between 1 April and 1 September 2020, 4% more than they received over the same period in 2019. Safeguarding concerns fell during the first England-wide lockdown in spring 2020, but rose rapidly after May 2020[72] as the government eased some restrictions.

This 4% rise might be slight, but it suggests that the quality of care people received fell – although the nature of referrals may have changed in comparison to previous years. The largest increases in referrals were from volunteers supporting people through the pandemic and the emergency services. Local authorities report that many of these referrals "did not meet Section 42 criteria for safeguarding enquiries"[73] and the increase may in part reflect different people coming into contact with, and thus raising concerns about, adults who had care and support needs, rather than an increase in the number of people experiencing or being at risk of abuse.

While safeguarding concerns rose, inquiries conducted by local authorities into safeguarding concerns fell, due to the difficulties of carrying out investigations during a pandemic, such as the need to carry out assessments remotely. Of the safeguarding inquiries that local authorities carried out, the biggest rises were cases of neglect, psychological abuse and domestic abuse within people's own homes, highlighting the difficulties local authorities had in getting assurance about the safety of people receiving home care.

While deaths and safeguarding inquiries are limited measures, they clearly suggest that local authorities and care providers struggled to keep people safe during the pandemic. As in the NHS, the government will have to review whether local authorities require more recurrent funding in the future – on top of the demographic, Covid legacy and reform pressures discussed below – to improve care providers' resilience to future shocks.[74] Local authorities and providers will not be able to enhance the quality or resilience of publicly funded care without additional funding. Local authorities told the National Audit Office that they were "reticent to challenge providers about their workforce development",[75] for example, because they accepted that low fees were a trade-off against actions providers could take to improve quality or resilience, such as investing in staff training.

How much would it cost adult social care to maintain pre-pandemic standards?

Demand for publicly funded adult social care will continue to rise quickly as a result of the ageing population and rising proportion of people with physical and learning disabilities in the working-age population; and the cost of providing that care will increase due to the planned rise in the national living wage, which the UK government plans to increase to two thirds of median earnings by April 2024.[76] After a decade of no real-terms growth in adult social care spending, there is little room left for local authorities to further reduce fees paid to care providers without making the care market even more unsustainable.

The government's plans to reform social care will require higher spending. In September 2021, the government announced that it will expand the state-funded adult social care offer by capping lifetime care costs at £86,000 after October 2023 and increasing the 'asset floor' – how much people can keep before the state pays for part of their care.[77] This expansion, along with a new obligation on local authorities to arrange care for self-funders if they choose,[78] will require higher local authority spending.

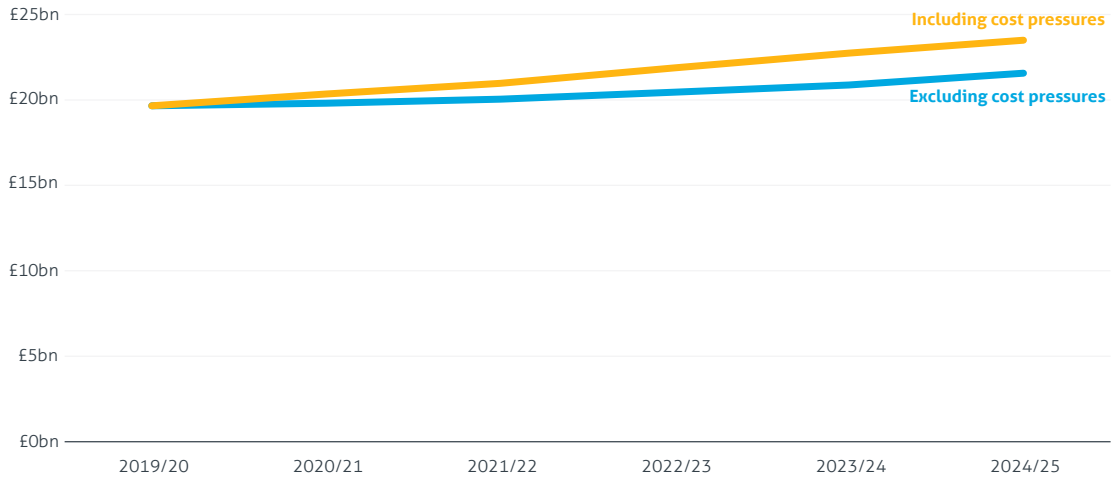
To fund these reforms, the government has allocated £5.4bn over three years – although this money has been bundled with additional funding to tackle the backlog of elective operations in the NHS. Front-loading funding to tackle the NHS backlog is risky, as previous funds for specific tasks for the NHS have ended up being swallowed into the NHS budget permanently.[79] Critical details are still missing. For example, local authorities do not know the taper rate: how much people will contribute to their care costs between the new upper and lower means test thresholds, or whether they will receive additional funding to cover the higher National Insurance costs that private and voluntary care providers will incur as a result of the National Insurance rise.[80]

We have not modelled the cost of this reform, but it will require higher public spending on adult social care. The Health Foundation estimates that implementing a cap of £78,000 (slightly below the government's proposed £86,000) and increasing local authority social care budgets by 10% a year to increase the number of people who receive state-funded care would cost an additional £4.3bn by 2024/25 (£2bn for a cap, and £2.3bn to expand access to care).[81] If government funding for local authorities is not enough to cover its reform plans, then local authorities may respond by tightening needs tests in order to provide care to the larger number of people who will pass the means-test for publicly funded care.[82]

Even if the government was not reforming the adult social care system, just maintaining existing standards of care would require more funding. If the government wanted only to maintain standards in the existing system, we project that public spending on adult social care would need to rise by 9.7% between 2019/20 and 2024/25. This projection factors in a faster rate of growth in demand for care among those aged 65 and over, and is based on data from the Care Policy and Evaluation Centre (CPEC).[83]

If the government wanted to fully cover the cost of implementing the national living wage – which will affect 62.5% of adult social care spending – then spending will have to rise faster: by 19.6% between 2019/20 and 2024/25.

Figure 3.7 **Spending required to maintain pre-pandemic standards in publicly funded adult social care**



Source: Institute for Government analysis based on NHS Digital, *Adult Social Care Activity and Finance Report*, December 2020, and Hu B, Hancock R and Wittenberg R, *Projections of Adult Social Care: Demand and expenditure 2018 to 2038*, London School of Economics and Care Policy and Evaluation Centre, December 2020 (see Methodology).

If local authorities can deliver services more efficiently, the government may be able to maintain the current scope and quality of care without increasing spending by as much as 19.6%. But local authorities' efforts to make efficiencies in social care during the 2010s were not sustainable,[84] and many ended up being reversed. Before the pandemic, almost all local authorities used the additional funding they received from the improved Better Care Fund grant to increase the fees they paid to care providers,[85] for example.

The legacy of the pandemic could increase spending higher than the projection outlined above. If the government wants to increase social care's resilience to a future pandemic, such as by increasing care worker training or maintaining greater infection control measures, it will need to spend more.[86] Local authority directors also report that the pandemic will increase the cost of care: 76% of directors reported that new burdens such as enhanced infection control measures and providers' higher insurance premiums[87] would temporarily increase the cost of providing adult social care in 2021/22.[88]

There is little scope to increase efficiency in the short term. Local authorities' efforts to hold down costs had already reached the end of the road by 2015, and longer-term projects to make savings – such as integrating health and social care or increasing investment in preventive activity to help adults remain independent for longer – are unlikely to pay off over the course of the spending review.

How much would it cost to address the legacy of the pandemic in adult social care?

In addition to these medium-term pressures, disruptions to publicly funded social care during the pandemic, such as day centre closures, may create further pressures. Adults who received less or no publicly funded care during the pandemic may have seen their health deteriorate to an extent where they will now require more care support. At the same time, some factors could decrease demand in the short term. The high death rate in care homes and subsequent public reticence about using them reduced occupancy by around 10 percentage points between February 2020 and May 2021. It may take several years for the flow of local authority residents into care homes to return to pre-pandemic levels. The extent of backlogs and unmet need as a result of the pandemic is hard to judge due to the lack of available data[89] on capacity, services provided, and to what extent these meet needs.[90] Improving data collection on waiting times and unmet need in adult social care should be a priority for the government.

The number of people who might require additional care as a result of the pandemic is highly uncertain so we do not model it – but the costs could be substantial. If 5% more adults require care during this and next year (2021/22 and 2022/23) than did pre-pandemic, and assuming that the cost of provision remains the same, local authorities would have to spend around £2bn more over the next two years to provide that care.

4. Children's social care

Local authorities faced immediate pressures at the start of the pandemic to ensure children stayed safe. Residential care placements rose, at cost, but despite the efforts of social workers, the volatile conditions of the pandemic made it harder for families to receive help. Despite many children living in riskier environments during the pandemic, referrals to children's social care fell dramatically. More children were harmed during the pandemic: there were 536 child deaths or other incidents of serious harm to a child in 2020/21, a 19% increase on 2019/20.

Local authorities will have to spend more if, as expected, there is a surge of referrals for children who needed but missed out on care during the past year. If even half of these return in 2021/22, local authorities would have to spend an additional £840m by 2024/25.

This chapter focuses on children's social care in England. Upper tier county and unitary local authorities provide these services and are legally obliged to provide support for disabled children, protect children from harm, and take responsibility for 'looked-after children', including through foster and residential care placements.

Local authority spending on children's social care rose during the pandemic, especially on residential care placements

Children's social care spending was already rising rapidly before the pandemic, owing to growing numbers of children who required intensive support. In fact, children's social care and adult social care are the only local government services where spending was higher in 2019/20 than it was in 2010/11.[1]

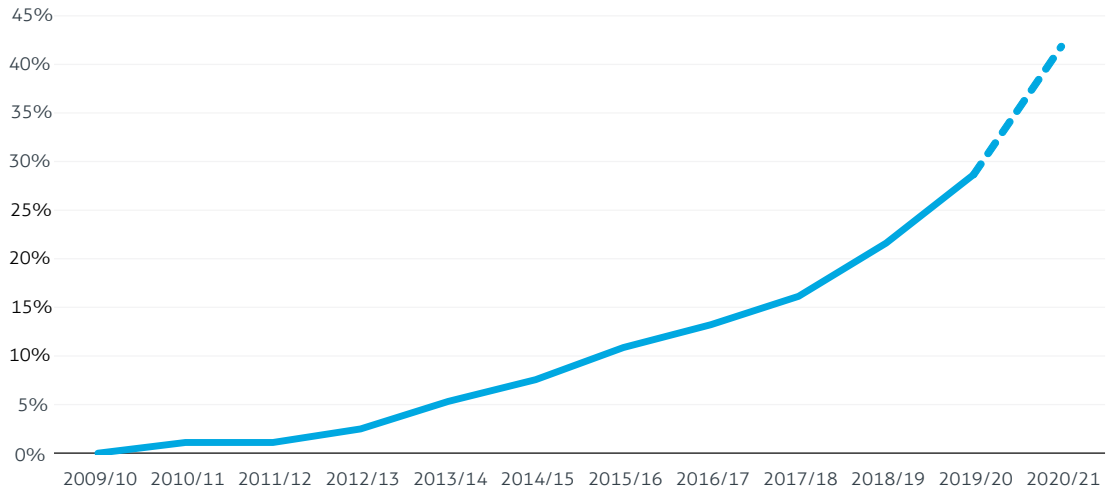
The pandemic put additional pressures on children's social care. Local authorities spent £420m extra on it between April 2020 and March 2021 – equivalent to 4.3% above the children's social care budget for 2020/21, made before the pandemic.[2] If spending changes in line with budgets that include Covid costs, local authorities will have spent 10% more on social care for children in 2020/21 compared to 2019/20.[*] Local authorities funded this extra spending from the overall funding central government provided to local authorities to handle the extra direct and indirect costs of the pandemic.[**]

* We estimate this by assuming all the reported Covid spending on children's social care was additional. For more on our calculations see the Methodology section at the end of this report.

** In addition to the funding provided to local authorities, the government provided £66m for projects to support children's social care that were not delivered by local authorities. The largest single item was emergency support for charities that support vulnerable children (£29.2m), in recognition of the greater risks children faced during the pandemic. See National Audit Office, 'COVID-19 cost tracker', (no date), retrieved 4 October 2021, www.nao.org.uk/covid-19/cost-tracker

Local authorities spent more than expected on staff as many social workers were unable to work while they were self-isolating, particularly during May 2020 and January 2021.[3] The biggest single extra item was, however, additional spending on residential care – children's homes.

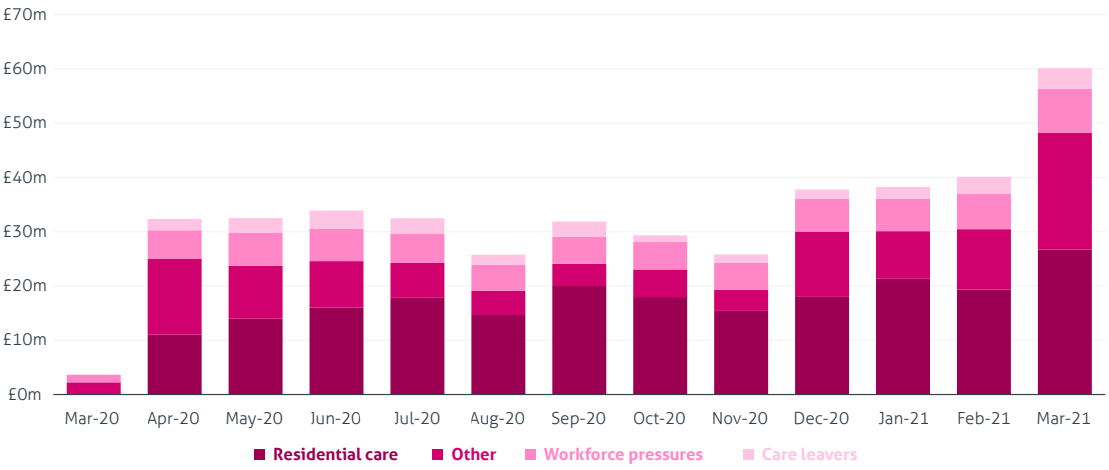
Figure 4.1 **Change in local authority spending on children's social care in England since 2009/10**



Source: Institute for Government analysis of DfE, 'LA and school expenditure'; MHCLG, 'Local authority revenue expenditure and financing', 2019–20 & 2020–21 Budget, England; MHCLG, 'Local authority COVID-19 financial impact monitoring information'.

The cost of placing children in residential care rose sharply during the pandemic. This reflected two underlying factors. The first was the higher costs that care homes themselves faced for additional infection control measures, such as staff PPE and cover staff.[4] The second was the fact that the pre-existing shortage of care placements was further reduced during the pandemic, raising prices. This continues a long-running trend of rising costs of residential care for children, which began in 2015/16,[5] though the increase in 2020/21 was much sharper than in previous years.

Figure 4.2 **Additional local authority spending on children's social care in 2020/21**



Source: Institute for Government analysis of MHCLG, 'Local authority COVID-19 financial impact monitoring information'.

To reduce the risk of transmitting infections, some independent residential care providers declined to accept new children during the first lockdown.[6] At the same time, a reduction in foster care placements, as foster carers either shielded or self-isolated,[*] increased local authority demand for residential care. As a result, local authorities often paid more for the remaining available private fostering and residential care places.[7] By September 2020, 84% of local authorities reported that the weekly costs of residential care had increased due to coronavirus, with 19% reporting that it had increased by 11% or more.[8]

Ofsted data shows that the increase in demand resulted in more new homes being registered. The number rose by 133 to 2,592 between April and August 2020 – the highest since 2012.[9] This is also part of a longer-term increase since 2015 – but some of these registrations were fast-tracked where local authorities urgently needed provision during the pandemic, notably in London. Of the 176 sites opened between April and August 2020, 23 were re-registrations, suggesting that local authorities and providers reopened old homes to cope with the additional demand.

The sharp rise in the cost of places seen during the pandemic should be temporary. However, while the immediate pressures should ease as foster and residential care places become more readily available and local authorities build more publicly run homes,[10] building new placements will take time and costs will continue to be high while they are being built. In addition, increases in the national minimum wage and the increasing complexity of children's needs will increase the cost of provision (and the prices that providers charge)[11] in the near term.

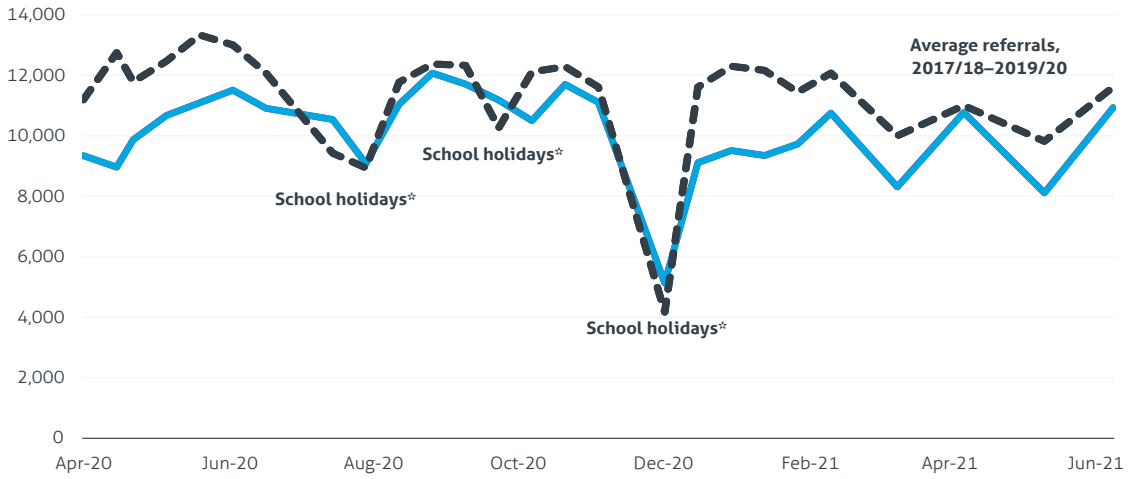
Local authorities received fewer referrals during the pandemic

The most visible impact of the pandemic was the huge fall in referrals of potentially vulnerable children to local authorities. There were 252,000 referrals between the end of April 2020 and the start of July 2021 from members of the public, charities and other public services. This was 11% fewer than the average number of referrals in the same weeks over the previous three years.[12]

This is partly because public services that would normally refer children to local authorities – such as schools, police and health visitors – had less contact with children. Schools were responsible for around a fifth (18%) of all referrals before the pandemic.[13] During the England-wide school closures – that is, between March and June 2020 and January and March 2021 – the number of referrals per week from schools fell dramatically, and was between 41% and 76% lower than in pre-pandemic years.[14] Worryingly, referrals from schools remained below typical levels even when all children returned to school in September 2020. Charities and local authorities had expected a rapid increase in referrals when children returned to school, to above normal levels,[15] but this did not happen.

[*] On 31 March 2020, 65% of foster carers in England were over 50 years old, and 25% were over 60. See Ofsted, 'Fostering in England 2019 to 2020: main findings', GOV.UK, 12 November 2020, retrieved 4 October 2021, www.gov.uk/government/statistics/fostering-in-england-1-april-2019-to-31-march-2020/fostering-in-england-2019-to-2020-main-findings

Figure 4.3 **Referrals to children's social care**



Source: Institute for Government analysis of Department for Education, *Vulnerable children and young people survey: waves 1-26.* * Comparison for these weeks is affected by variation in timing of school holidays each year.

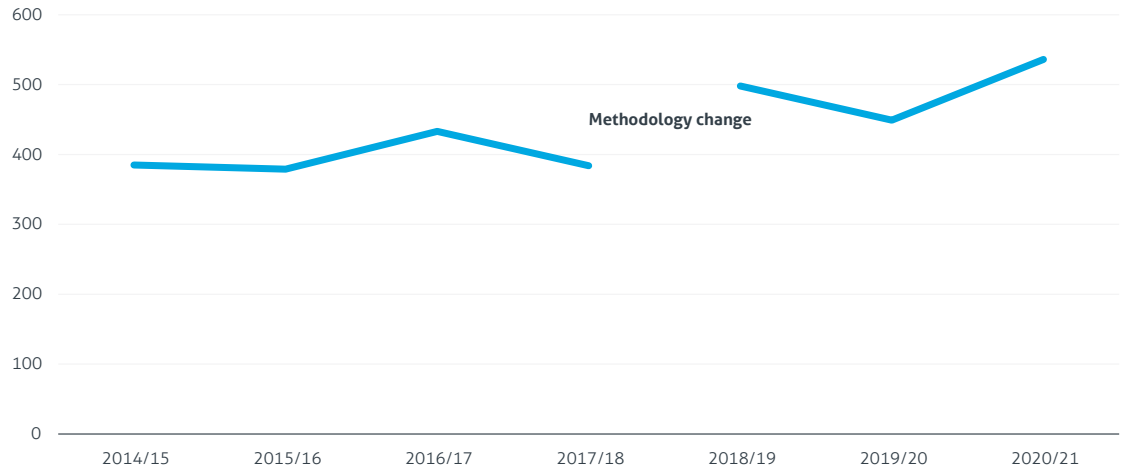
The reduction in referrals almost certainly does not reflect a fall in children in need or at risk of serious harms. The pressure-cooker environment of the England-wide lockdowns increased the family and environmental risks facing children[16] – from domestic abuse[17] to lack of opportunities for children and social isolation.[18] Other sources of evidence on the number of children in need, such as abuse helplines, suggest that there has been an increase in 'hidden harm' (including a reported increase in online harms) – children at risk who local authorities do not know about. The National Society for the Prevention of Cruelty to Children reported that its helpline, which allows adults to raise concerns about children, received 85,000 contacts between April 2020 and March 2021, a 23% increase on the year before.[19] Calls to

Childline, a phone-based counselling service for people aged under 19, also rose, with a particularly sharp increase in demand for counselling from children aged under 11 and counselling about emotional abuse.[20]

Estimating the number of 'hidden' children at risk of harm is difficult. By definition, they are not known to local authorities, but it is highly likely that some families in need of support and children at risk of harm have not received the help they otherwise would have done in the absence of the pandemic.

There is, sadly, evidence that more children have come to harm as a result. Local authorities have been required to notify Ofsted of serious incidents, where a child known or suspected to be at risk of abuse or neglect dies or is seriously harmed, since 2014/15. There were more than 500 such cases in 2020/21, the highest level since this information started to be collected from all local authorities. The Child Safeguarding Review Panel, which oversees reviews of serious child safeguarding cases, found that the pandemic was a factor in many of these. It found that higher parental and family stress as a result of the pandemic was a particularly important factor in incidents of neglect, non-accidental injury, and sudden unexpected deaths of infants.[21]

Figure 4.4 **Serious incident notifications***

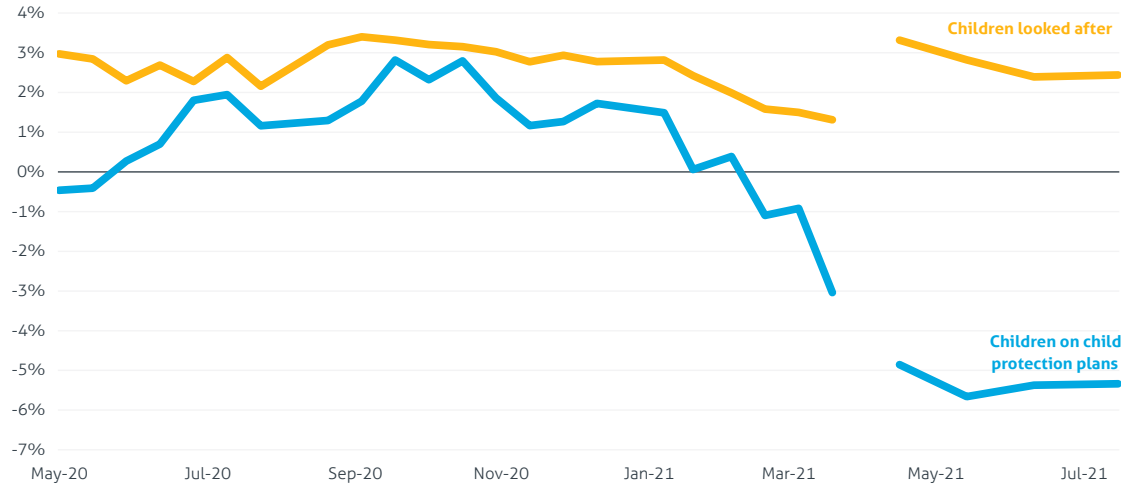


Source: Institute for Government analysis of Department for Education, 'Serious incident notifications'. * The notification criteria for local authorities to report serious incidents changed in July 2018.

Local authorities supported a similar number of children during the pandemic

While fewer referrals came in, social workers continued to have similar workloads as they did before the pandemic because fewer children left local authority care or supervision. The number of 'looked-after children' (whom a local authority provides with accommodation for a continuous period of more than 24 hours or is subject to a care or placement order) and children on child protection plans was slightly higher throughout most of 2020/21 than in 2019/20.

Figure 4.5 **Difference in the number of children on child protection plans and looked after children compared to 2019/20***



Source: Institute for Government analysis of Department for Education, *Vulnerable children and young people survey: waves 1 to 26*, Figure 1. Figures kindly provided by Department for Education. * = From 19–21 April 2021, data is not directly comparable because it compares numbers to data from two years ago in 2019/20 (not to data from 2020/21).

The number of children on a child protection plan was higher throughout most of 2020 than it had been in 2019. This was because the number entering child protection decreased only slightly, but the number leaving decreased substantially. The rate of children starting child protection plans fell only 1% between Q2 2019/20 and Q2 2020/21* and local authorities reported that some children referred were quickly made subjects of plans at the start of the pandemic.

At the same time, children already on plans stayed on them for longer.[22] Local authorities reported that social workers, police officers and teachers involved in child protection conferences were "reluctant to remove children from those plans due to anxiety about the lived experiences of some children deteriorating through the pandemic, [and concerns] that interventions and support, such as mediation, drug and alcohol services, and third sector services were not operating fully".[23] Six in 10 (62%) social workers surveyed by the Department for Education (DfE) thought that the pandemic had negatively affected the resources available to support children and families. Perhaps unsurprisingly, the Association of Directors of Children's Services (ADCS) estimates that 4% more children were on child protection plans in September 2020 compared to September 2019.**

Local authorities also reported that fewer children became 'looked after'[24] and many fewer still departed from care during the pandemic. DfE estimates that 10,600 fewer children became looked after between May 2020 and July 2021 than would have done if the average entry rate over the previous three years had been maintained during the pandemic.[25]

This was partly caused by delays in the family courts increasing the time it took for local authorities to take children into care or move them to adoption, special guardianship, or back to their family homes.[26] The average duration of section 31 'care and supervision' orders, in which local authorities apply for a court order to safeguard children,[27] rose from 36 weeks between April and June 2020 to 43 weeks between January and March 2021.[28] Delays in court proceedings have both harmed children's wellbeing and put pressure on foster and residential home placements, where they have had to stay until proceedings are finished.[29] Taking both fewer entries and exits from care into account, ADCS estimates that there were 2.6% more children looked after in September 2020 than in September 2019.[30]

The rises caused by fewer children leaving protection plans and care during the pandemic should be temporary, and the number of children on child protection plans and looked-after children started to fall in January and February 2021.

* Data on the inflows and outflows into child protection and looked after children is from the ADCS *Safeguarding Pressures* report, which reports data only until September 2020. Department for Education data for the full 2020/21 financial year will be published in October and November 2021 respectively.

** ADCS estimates differ from the Department for Education's estimates because both are based on surveys of local authorities where not all local authorities responded.

The pandemic reversed a trend of decreasing child protection and care interventions. The number of children on child protection plans, for example, had reduced by 4.2% between 2017/18 and 2019/20, from 53,800 to 51,510.[31] Likewise, the number of children who started to become looked after had decreased after 2016/17,[32] although fewer looked-after children left care so total numbers increased after 2016/17.

Social work changed during the pandemic

While the number of children that each social worker supported was similar during the pandemic to the period before, the nature of their work changed. With restrictions on face-to-face contact, social workers made greater use of remote working tools. Despite difficulties contacting children, social workers remained in contact with most children who they knew needed support. Between May 2020 and July 2021, social workers consistently contacted – either face-to-face or remotely – 95% of children on child protection plans, 70% of looked-after children and 60% of other children in need within four weeks,[33,*] despite having to handle slightly more cases and switching to primarily remote contact during the second and third England-wide lockdowns.

Children's residential homes in particular struggled during the pandemic. Residential care workers, who are not normally expected to educate children, found themselves having to teach some of the most vulnerable and emotionally traumatised children, without being able to organise many of the normal activities to relieve pressure – such as allowing children to see family members in person. While some homes managed this well, many others struggled. In a series of assurance visits to homes in September 2020 Ofsted found that most homes kept children safe and maintained remote contact with friends and family, but struggled to facilitate contact with other specialists, such as psychologists and therapists.[34]

The biggest change was the switch to remote working for most assessments, meetings and court cases. At the start of the pandemic, DfE issued guidance[35] stating that contact between children in care and their families should be conducted remotely to reduce virus transmission. While this worked well – in some cases better – for older children, who could easily access the internet and who found virtual contact more convenient,[36] it was difficult for parents and less effective for children aged under five, who were harder to engage remotely.[37]

Assessments and court cases were also largely undertaken remotely, which proved equally challenging. In a survey of what parents, carers and professionals thought of remote child protection conferences, all largely conducted remotely during the first England-wide lockdown, parents had strikingly different views from social workers. A sample of social workers said, when surveyed in September and October 2020, that they thought there had been some benefits – 50% thought they were better, 35% worse, and 17% on balance no better or worse.[38] Most thought they allowed for a wider range of professionals to participate because they did not have to be in a specific location, although most worried about the problems outlined above – notably that the remote format could exclude children and families.[39]

* DfE did not publish data on local authority contact rates before May 2020 so we cannot say how, if at all, these differ from pre-pandemic contact rates.

Most parents, however, found it much harder to participate in the conferences, and one interviewee thought they "would have had a different outcome to the conference if we had all been in a room together where we'd been able to talk properly, rather than having to take it in turn to speak".[40] Fewer parents responded to the survey, but all parents interviewed said they would have preferred a face-to-face conference.[41]

Remote court cases present a similar picture. A rapid survey of what parents, carers and professionals thought of remote hearings in April 2020 found that most respondents worried about the parents' ability to fully participate in hearings and the difficulty of interpreting reactions and communicating sensitively over video.[42] Parents, for example, often struggled to speak to their advocates during hearings as there were often not facilities for private discussions.[43] These concerns proved prescient. In a follow-up survey in September 2020, parents and family members involved in cases reported numerous problems. Almost all (88%) of parents and relatives who responded to the survey said they had concerns about the way their case had been dealt with, 66% said that their case had not been dealt with well,[44] and 40% said they had problems understanding the hearing; 20% said they did not understand at all.[45]

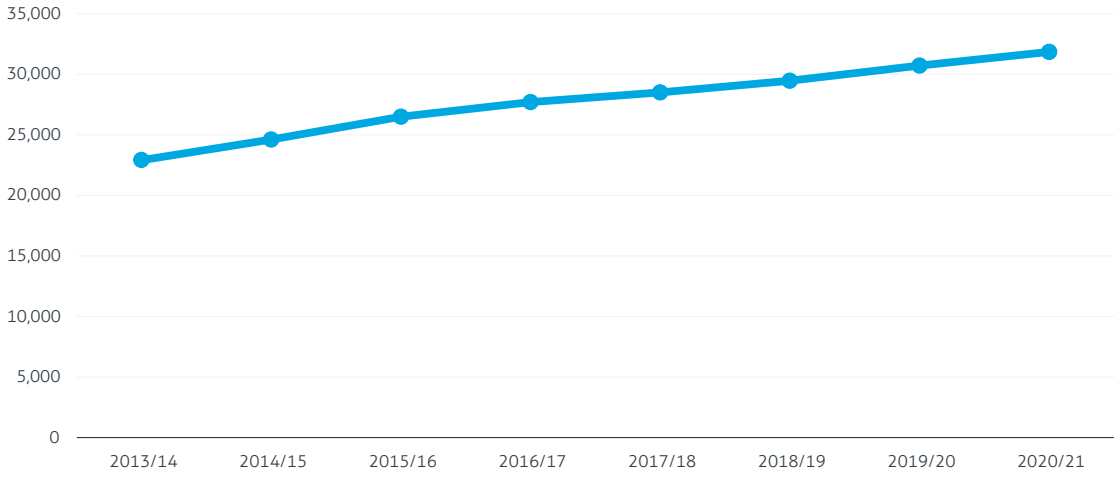
Despite these problems, making greater use of remote technology may be appropriate in some cases. Children's homes, for example, say they will keep remote working for team meetings[46] and social workers have expressed support for using remote hearings for 'administrative' hearings – that parents typically tend not to contest.[47] Given the large number of family court cases waiting to be heard – the number of outstanding cases stood at just over 14,200 in November 2020,[48] the last available data – the potential harm of remote court case hearings will have to be balanced against the harm of further delaying cases.

While research during the pandemic has explored the benefits and drawbacks of remote working for professionals and parents, the existing evidence largely does not include children's views on remote contact.[49] This needs to change. DfE, family courts and local authorities all need better evidence on what children – whose welfare is the ultimate purpose of the service – thought about the changes during the lockdown. The department and the courts should commission research exploring what children thought about remote child protection conferences and court case hearings, and how they could be improved. This could start by adding questions to the annual Ofsted social care survey,[50] which asks children about their views of children's social care.

Social worker vacancies and turnover fell during the pandemic

The number of children's social workers in England continued to grow during the pandemic, to almost 32,000 in September 2020, 3.7% more than in September 2019. This continued the trend before the pandemic, albeit at a slower rate – the compound annual growth rate between 2013/14 and 2019/20 was 5%.

Figure 4.6 **Number of children's social workers as of 30 September**



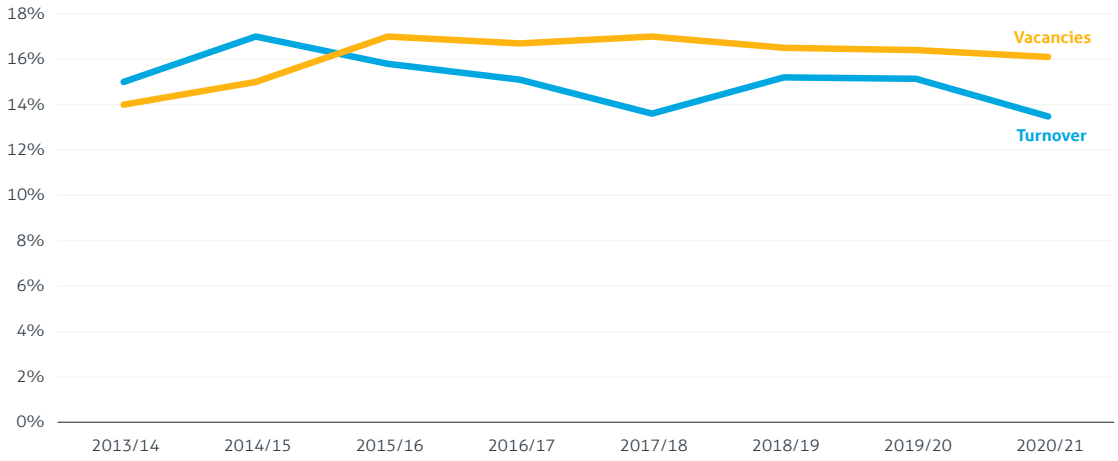
Source: Institute for Government analysis of Department for Education, 'Social worker workforce statistics'.

The number of children's social workers has been rising since 2013/14 after most local authorities hired additional staff to help deal with rising numbers of social work assessments, children on child protection plans and looked-after children.[51]

The increase between September 2019 and September 2020 continued this trend, although it also reflected DfE's efforts to increase staff numbers at the start of the pandemic. The Coronavirus Act, passed in March 2020, allowed local authorities to temporarily re-register social workers who had left within the last two years[52] – although only 32 social workers had been recruited directly through this national programme as of December 2020.[53]

The pandemic – at least temporarily – eased some recruitment and retention pressures. As in other public services, the improvements in recruitment and retention are related to the wider economic context. Economic uncertainty and lack of other job opportunities contributed to lower turnover and thus fewer vacancies than would otherwise have been the case. Both the vacancy rate and turnover rate (the number of staff leaving in a given year) decreased during the pandemic.

Figure 4.7 **Social worker vacancies as of 30 September and turnover rate during the preceding year**



Source: Institute for Government analysis of Department for Education, 'Social worker workforce statistics'.

Some of the changes to working practices during the pandemic may have improved recruitment and retention. The Centre for Public Impact, a think tank, found that some social workers said the quality of the relationships they had with existing children and families improved during the pandemic as children and families were more willing to engage through phone and video, though some said they had got worse.[54] Almost all social workers it interviewed were positive about reductions in travel time from more home-working. A DfE survey of social workers between September and December 2020 also found that social workers were positive about some changes. Four fifths said that coronavirus had increased flexible working,[55] and social workers at all grades reported a slight reduction in working hours from 42 hours between September 2019 and January 2020, to 40 hours between September and December 2020.

The principal reasons were reductions in travel time and time taken to co-ordinate meetings.[56] The mean number of cases the social workers were handling fell from 19 in between September 2019 and January 2020 to 18 between September and December 2020 – although some of this may have been offset by the increasing complexity of the cases they handled during the pandemic.

Local authorities struggled to hire experienced social workers before the pandemic,[57] so the reduction in turnover – if sustained* – should be beneficial. The number of social workers with more than five years' experience increased this year for the first time since DfE started collecting data on experience in 2015/16. This does not, however, offset the decline over the previous four years. Only 40% of staff had five or more years of experience in 2020/21, down from 51% in 2015/16.

* Despite some benefits to staff, many reported that working conditions had got worse. Two thirds of social workers said that the pandemic increased anxiety, complexity of cases and workload and almost three quarters said that work-related stress had increased. See Johnson C, Sanders-Earley A, Earl S, Winterbotham M, McLaughlin H, Pollock S, Scholar H and McCaughan S, *Longitudinal study of local authority child and family social workers (Wave 3)*, Department for Education, 2021, pp. 64–65.

The short-term reduction in vacancies and turnover owing to the wider economic context will not last. Despite more stressful working conditions, there has not been an increase in social workers saying they intend to leave. In a sample of social workers surveyed in September and October 2020, 90% said they anticipated continuing to work in social work, the same as when asked between September 2019 and January 2020.[58]

The quality of children's social care probably fell during the pandemic

Evaluating the quality of children's social care during the pandemic is difficult. Even before the pandemic, there was little comprehensive and reliable evidence on the impact that care has on children, or how this has changed over time.[59]

During the pandemic, the amount of information available declined further. Ofsted paused routine inspections of local authorities and care providers in March 2020,[60] and restarted standard inspections only in July 2021.[61] Ofsted visited 11 local authorities in September and October 2020 to assess practice[62] but did not assess how this compared to practice before the pandemic. Data on other indirect measures of quality – such as child protection re-referrals and reviews of child protection plans carried out within four weeks – is expected later in 2021 but was not available at the time of writing.

There are only two sources of quantitative information to judge how the quality of care provided has changed during the pandemic: surveys of social workers, and of children. Social workers report a mixed view of how the pandemic affected their relationships with children and families. In a survey conducted between September and December 2020, 44% thought their relationships had worsened, but 37% thought there had been no impact, and 15% thought the pandemic had improved relationships.[63] Children in residential homes surveyed by Ofsted – a relatively small section of the overall children's social care system – were slightly more likely to say they felt well cared for always or most of the time in February and March 2021[64] (96%) in comparison to February and March 2020[65] (94%), although there was no difference in how many children reported feeling safe where they stayed (94% in 2020 and 2021). Perhaps surprisingly, there was a slight rise in the proportion of children who said they felt involved in decisions about their lives in 2021 (82%), up from 79% in 2020.

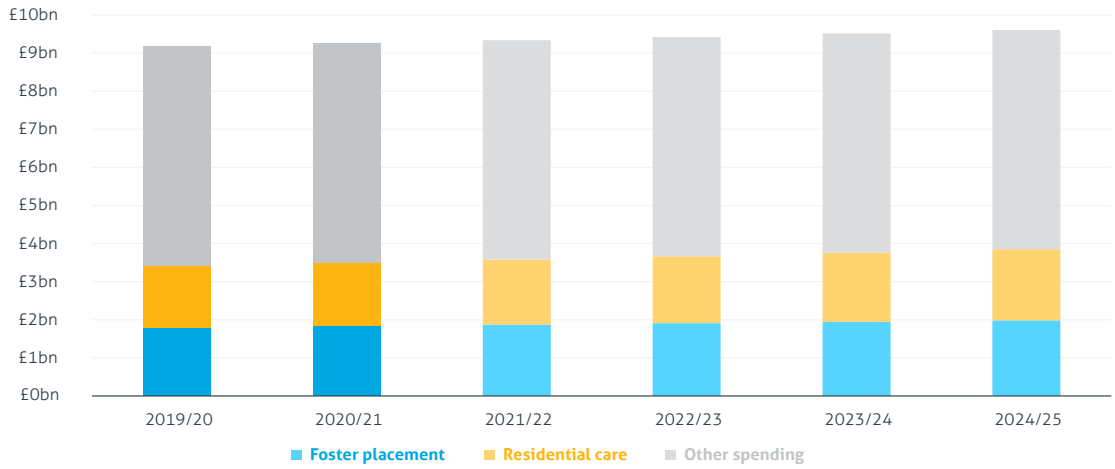
These snapshots are useful but they give only a partial picture. The wider evidence of the difficulties of remote social work and the increase in the number of children who were seriously harmed or even died during the pandemic suggest that, on balance, the quality of children's social care has worsened. Given the context of the pandemic, this is most likely to be due to the difficulty of identifying at-risk children. Given the lack of a broader base of evidence of children's views from across the care system, the government must prioritise collecting more evidence on what children thought about the changes during the lockdown and how remote contact, if it is used again, could be improved.

How much would it cost children's social care to maintain pre-pandemic standards?

If the pre-pandemic trends of rising numbers of looked-after children and children on child protection plans continue, demand for children's social care will continue to rise. While the rate of children-in-need has fallen at a slow rate since 2017/18,[66] rates of looked-after children and children on child protection plans – who require more intensive and expensive support – have continued to rise.

We project that demand for children's social care will grow by 4.8% between 2019/20 and 2024/25 – driven by increasing demand for foster and residential placements.

Figure 4.8 **Spending required to maintain standards in children's social care**



Source: Institute for Government analysis of Department for Education, 'LA and school expenditure' (see Methodology).

This assumes that the prevalence of children in foster and residential care continues to grow at the same average annual rate seen since 2007/08.* We assume that demands for other areas of children's social care – that is, services for looked-after children, safeguarding services and family support services – will grow at the same average annual rate as the number of episodes of children in need since 2012/13, which is the first year for which consistent data is available.

These projections suggest that local authorities would need to spend £436m a year more in real terms by 2024/25 than they did in 2019/20 to meet growing demand, and to maintain the scope and quality of children's social care, assuming that local authorities can continue to deliver these services as efficiently as they were in 2019/20.

On the face of it, local authorities would not have to increase spending particularly quickly to meet demand – but there are many pressures that could force local authorities to spend more.[67] There was a shortage of appropriate foster and residential placements before the pandemic that contributed to rising placement costs between

* We start from 2007 because that is the year Peter Connelly (Baby P) died. His death was widely reported, prompting a marked increase in the number of children taken into care in England.

2015/16 and 2019/20[68] and caused particular problems during the pandemic when fewer children left care, making it harder to find new placements. Local authorities still report that they are struggling to recruit social workers[69] and they may have to spend more to attract enough staff into the workforce.

How much would it cost to address legacy of the pandemic in children's social care?

The biggest impact of the pandemic was the huge fall in referrals of potentially vulnerable children to local authorities. Between the end of April 2020 and the start of July 2021, there were 11% fewer referrals than the average number of referrals in the same weeks over the previous three years. Given that pressures on families and risks to children increased during the pandemic, the decline in referrals is unlikely to indicate a genuine decline in need. At least some of the 'missing referrals' – children who were not referred during the pandemic – are still likely to need support in the future.

To estimate the number of children who might be referred beyond the expected changes in demand described above – and how much it might cost local authorities to support these children – we modelled three scenarios:

- A low scenario where referrals do not present later and demand continues to change in line with pre-pandemic trends, as described above
- A central scenario where half of the 'missing referrals' return between July 2021 and July 2022
- A high scenario where all missing referrals return between July 2021 and July 2023.

In the central and high scenarios, local authorities would have to spend more to support the increased numbers of children in need and looked-after children as a result of temporary higher referrals. Such cases can require local authority support for several years. In 2019/20, 21% of children-in-need who were no longer provided with services had been recorded as a child in need for at least one year, and 24% of looked-after children who left care had received care for at least one year. In both the central and higher scenarios, a recovery in referrals will therefore increase demand for several years, with the biggest in-year impacts coming in 2021/22 in the central scenario and 2022/23 in the high scenario.

Overall, the central scenario implies that local authorities would have to spend £536m more on children in need and £305m more on looked-after children between 2021/22 and 2024/25; the figures rise to £1.1bn and £603m in the high scenario. There are many uncertainties in these projections. To simplify, we assumed that the number of children who left care during the pandemic fell at the same rate as entry from lower referrals – although in practice they appear to have fallen at a slower rate as local authorities kept children in care for longer and took longer to discharge children due to backlogs in the family courts (see above). Local authorities may never discover some children who were missed and referrals may not increase above pre-pandemic levels after July 2021. Alternatively, referrals may increase even higher than we project in the high scenario.

The cost of supporting children referred later – who may have had extremely difficult home lives during the pandemic – may also be higher than normal. These children may require more extensive support than they would have done if they were referred earlier – and it may be harder for the usual outreach services to identify them. Just over two thirds (68%) of social workers thought cases had become more complex during the pandemic[70] owing to the stresses on families during the pandemic and receiving referrals only when families reached 'crisis points'.[71]

In the summer of 2020 local authorities told DfE that they were seeing an increase in placement breakdowns as children struggled with lockdown restrictions, resulting in them moving those children to more expensive placements.[72] Between September 2020 and July 2021, an increasing number of local authorities asked about demands on children's social care described an increase in the complexity of their cases, typically relating to elevated mental health problems among children and parents, parental alcohol problems and non-accidental injuries. Notably, some local authorities reported higher proportions of referrals resulting in assessments and provision of services – suggesting that children now being referred will need more support than children referred before the pandemic.[73]

5. Neighbourhood services

Local authorities spent much more than budgeted during the pandemic, notably on public health – where many set up new Covid contact tracing teams – and homelessness support. Central government funding was not enough to cover all spending pressures and lost income, so many local authorities made unplanned in-year cuts, adjusted their financial planning or drew on their reserves to balance budgets, leaving some less financially resilient.

Local authorities adapted to the crisis quickly by redeploying staff and suspending routine inspections to establish new services such as contact tracing. As far as can be measured, resident satisfaction increased and local authorities undertook more activity than normal in some services – such as road maintenance, which led to an apparent improvement in the quality of roads.

The longer-term consequences of reductions in routine activities are concerning, however. There are backlogs in issuing ratings for food hygiene and health and safety that, due to staff shortages, cannot be fixed in the short term. The government and local authorities face tricky decisions about how to catch up with limited staff and whether – if those gaps cannot be bridged through efficiencies – to reduce standards.

In addition to social care for adults and children, local authorities also provide other 'neighbourhood' services; this chapter focuses on these in England. There are 353 unitary, London, metropolitan district, shire district and shire county local authorities, funded in part by central government grants and in part by locally raised revenues, namely council tax.[1]

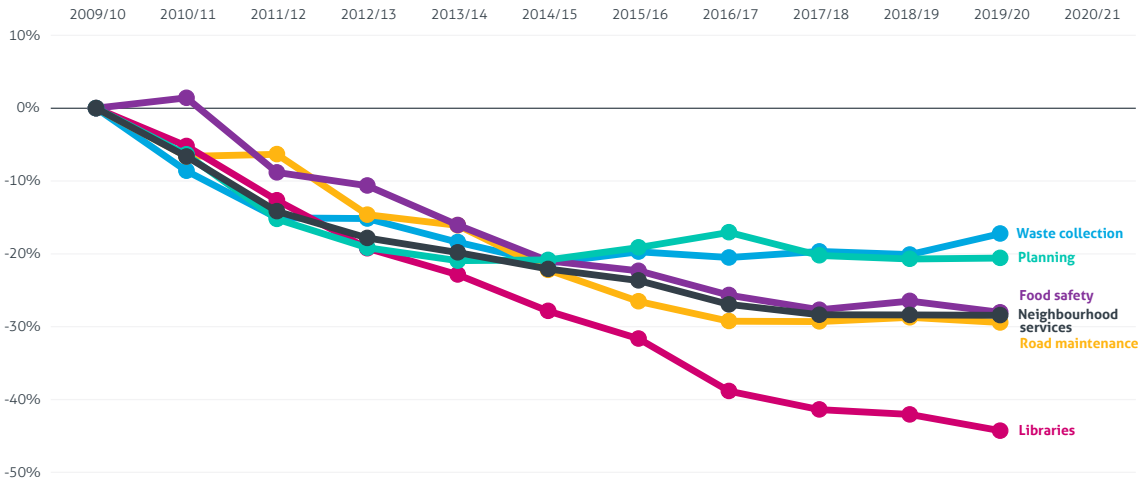
The seven neighbourhood services we look at for which some England-wide comparable data is available are: food safety, health and safety, libraries, planning, road maintenance, trading standards, and waste collection. To provide context, we refer to spending on and performance of other local services including public health, homelessness services and housing benefit.* We analyse neighbourhood services separately from locally provided social care for adults and children (see Chapters 3 and 4) because these other local services have been cut more severely over the past decade.[2]

* We do not cover these services because there are fewer output or outcome measures that we can judge performance against.

The UK government allocated local authorities £10.4bn to cover pandemic costs in 2020/21

Local authority spending on neighbourhood services had been squeezed deeply in the decade before the pandemic, owing to cuts to central government grants and local authority prioritisation of statutory responsibilities – services local authorities are legally obliged to provide – notably demand-led social care for children and adults.[3]

Figure 5.1 **Change in local authority spending on neighbourhood services in England since 2009/10**



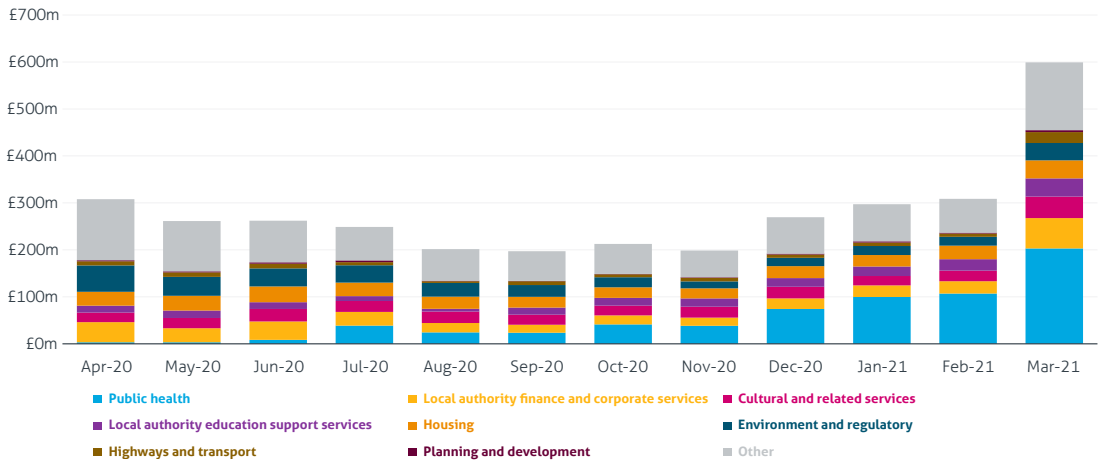
Source: Institute for Government analysis of Department for Levelling Up, Housing and Communities, 'Revenue Expenditure and Financing England', RO2 & RO5.

Comprehensive data on local authority spending during 2020/21 was not available at the time of writing, but spending on some services most likely fell because of closures during the pandemic. Libraries, for instance, remained closed in most local authorities during the first wave.[4] Spending on other services rose, however, because local authorities could complete more work during the lockdowns. The Asphalt Industry Alliance estimate that total road maintenance spending was higher in 2020/21 than in 2019/20[5] owing to additional central government grants and local authorities undertaking more repairs while there was reduced traffic during the first UK-wide lockdown. The annual local authority road maintenance survey of local authority highway departments found that local authorities filled more potholes in 2020/21 than in 2019/20,[6] although the cost of doing so was more expensive due to the cost of complying with Covid restrictions.[7]

Most additional local authority spending during the pandemic was not on neighbourhood services. Excluding social care, the single biggest category of additional spending was public health. Local authorities began to spend much more on this after June 2020, when the government provided funding to local authorities in the Test and Trace Support Service (later Contain Outbreak Management Fund) grant.[8] Some authorities set up their own contact tracing schemes to trace the contacts of the 'hardest-to-reach cases' – people who had tested positive but who national Test and Trace staff had not been able to reach within 24 hours.

In its July 2020 business plan, NHS Test and Trace planned to "strengthen collaboration with local government to further enhance contact tracing in relation to more complex cases"[9]. Following evidence that suggested that locally run schemes could reach some people which Test and Trace staff could not,[10] many local authorities established their own contact tracing teams. As of March 2021, 149 out of 151 social care authorities* were running local schemes[11] and NHS Test and Trace had begun to delegate some routine as well as hard-to-reach cases to local authorities.

Figure 5.2 **Additional local authority spending on non-social care services (£m)***



Source: Institute for Government analysis of MHCLG, Local authority COVID-19 financial impact monitoring information. * Excluding social care for adults and children, police, fire and rescue, and unachieved savings.

There was limited extra spending on the neighbourhood services this chapter analyses, although local authorities did spend £173m more on waste collection and disposal in the 2020/21 financial year[12], equivalent to 5.4% of how much local authorities had planned to spend in 2020/21[13]. As with road maintenance, higher spending on waste collection reflects more activity and higher costs of delivery due to the need for social distancing and more staff. Local authorities collected more household waste and recycling because of home-working and changes in shopping habits during the pandemic.[14]

Local authorities cut services and used reserves to cover costs during the pandemic

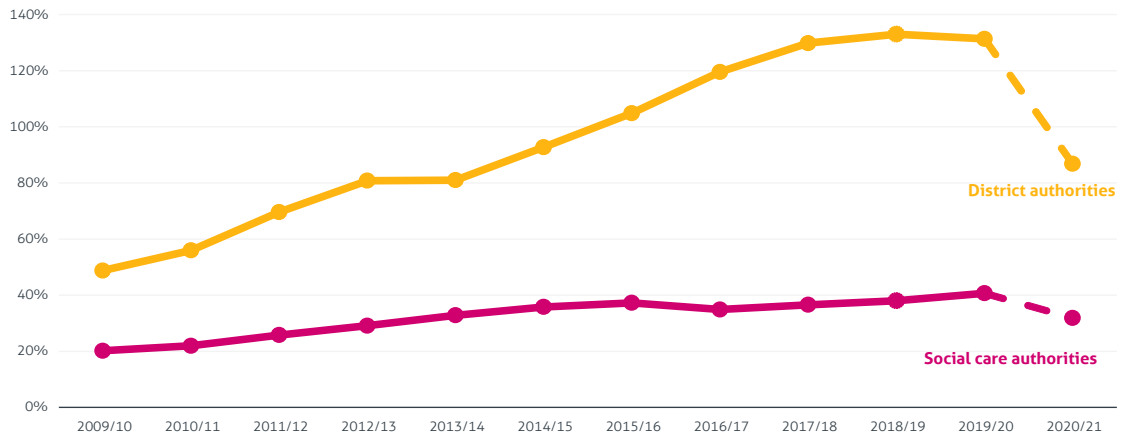
The additional £10.4bn the government provided to local authorities in 2020/21[15] did not cover all additional costs and lost income for all local authorities[16]. As a result of these shortfalls, the uncertainty about what costs government would cover at various times, and local 'funding gaps', some local authorities made unplanned cuts to services in the 2020/21 financial year.

When surveyed in December 2020, some 53% of local authority finance officers in social care authorities and 59% of officers in district councils said that they had made unplanned savings from service budgets. In social care authorities, 46% dipped

* Local authorities responsible for social care – unitary, London borough, metropolitan district, and shire county local authorities. See Paun A, Hall D and Wilson J, 'Local government', Institute for Government, 21 May 2021, retrieved 14 October 2021, www.instituteforgovernment.org.uk/explainers/local-government

into their reserves (72% in district councils) to cover coronavirus pressures and avoid running a deficit.[17] In aggregate, social care authorities' usable reserves – total earmarked and unallocated reserves not ring-fenced for a specific service* – fell from 40.7% of annual spending in 2019/20 to 31.9% in 2020/21, and district authorities' usable reserves from 131.3% to 86.8%.

Figure 5.3 **Local authorities in England: usable reserves as a percentage of annual expenditure***



Source: Institute for Government analysis of Ministry of Housing, Communities and Local Government, Revenue outturn summary (RS); Revenue account budget (RA), 2020/21. * Usable reserves are the total of earmarked and unallocated reserves, excluding school reserves and public health reserves. Annual expenditure is net expenditure excluding education services (schools) and public health. This excludes combined authorities, rire and rescue authorities, waste authorities, national park authorities, and police and crime commissioners. 2020/21 figures are taken from budgets rather than outturns.

On the surface, this is not obviously a problem. Local authorities hold reserves to meet unexpected pressures and so using them to respond to the pandemic is entirely logical. On average, local authorities are now roughly back to the level of reserves they held in 2013/14 – but the pandemic hit local authorities differently, and some now have concerningly low levels of reserves. The National Audit Office estimated, using an MHCLG risk framework, that 1.5% of local authorities were at acute risk, 5.9% at high risk and 27.3% at medium risk of having insufficient reserves to cover Covid funding pressures (that is, funds to cover unexpected shocks) as of March 2020.[18] This is particularly concerning after a decade of pressures on local authority finances, and substantial increases in local authority spending to acquire commercial property for investment between 2015/16 and 2017/18.[19]

* Local authorities can in theory use earmarked and unallocated reserves to cushion unexpected in-year financial pressures. We do not include schools or public health reserves as they are specific to those services. We include earmarked reserves as, in principle, they can be released for other purposes. Unallocated reserves can be used to meet unexpected pressures although in practice not all are available because local authorities are required to "hold sufficient reserves to accommodate the risks associated with their budget". Comptroller and Auditor General, *Local government finance in the pandemic*, Session 2019–20, HC 1240, National Audit Office, 10 March 2021, p. 48.

In addition to using reserves, local authorities also managed their finances by transferring capital (money earmarked for investment) to revenue (day-to-day spending) budgets. Seven local authorities received exceptional 'capitalisation directions' to allow them to do this in 2020/21,[20] and many did so within services where moving money did not require a formal direction. For example, 44% of local authorities reported using capital money intended for highway improvements to fund regular maintenance work on existing roads.[21]

Local authorities' in-year spending cuts, use of reserves, and capital-to-revenue transfers were due not just to a general shortfall of funds but to delayed action from central government. Some local authority finance directors reported that the late announcement of local authority-level grants meant they were "planning in a vacuum".[22] Others that anticipated a low spending settlement reported being "cautious and cut services rather plan for efficiencies over the medium term".[23] In contrast, local authorities that anticipated a higher spending settlement delayed taking decisions on possible cuts. This recreated the problems in local authority financial planning after the 2008 financial crash and ensuing recession, when uncertainty about the size of future cuts led to many local authorities delaying planning.[24]

The temptation for cautious cuts and delaying decisions will persist until a longer-term funding settlement provides some certainty on medium-term planning. When surveyed in December 2020, 94% of social care authorities and 81% of district councils said they intended to reduce service budgets in 2021/22. Most (68%) social care authorities and district authorities (82%) also intended to use reserves to balance budgets in 2021/22.[25] These pressures have continued in 2021. In a survey of local authority directors of human resources in July 2021, a quarter (24%) said they intended to reduce staff numbers in the 2021/22 financial year.[26] The Institute for Fiscal Studies estimates that if Covid pressures on local authorities persist over the rest of 2021/22 at the same level as between July and September 2021, local authorities will face a £0.7bn shortfall of unfunded pressures.[27]

The government should provide a multi-year settlement for local authorities in the October 2021 spending review to provide this certainty. While short-term grants have been effective at addressing emergency problems, and were understandable in the earlier phases of the pandemic, they make it hard for local authorities to plan strategically and are not an effective way of spending money. Local authority staff who worked on the Everyone In homelessness programme – where local authorities offered accommodation to all rough sleepers and people at risk of becoming rough sleepers – for example, said that more clarity about funding would reduce turnover and reliance on agency labour.

Some funding, such as the Next Steps Accommodation Programme, had to be spent by the end of March 2021,[28] for example. When asked about their top concerns, 73% of council officers who responded to the Local Government Association's survey on rough sleeping during the pandemic identified the need for longer-term funding to help recruit and retain staff and support strategic planning.[29]

Local authorities delivered many services remotely during the pandemic

Local authorities quickly adapted to the pandemic and continued to provide valuable services such as access to green spaces. Local authorities kept parks, which were in much higher demand in 2020,[30] open while redeploying park staff to Covid work such as supporting vulnerable adults.[31]

Other services were delivered remotely during the pandemic. While some – most obviously road maintenance – could not be delivered virtually, others could. Libraries, for example, shifted to virtual provision during the first nationwide lockdown. LibrariesConnected, a membership organisation for libraries in England, Wales and Northern Ireland, estimates that libraries in England loaned 3.5 million more ebooks than normal between March and August 2020.[32] Libraries ran some services that they had previously run in-person, such as book clubs and services for children, including Story Time and Rhyme Time.[33]

Similarly, most planning meetings were undertaken virtually during the pandemic and by June 2020 around 70% of local authorities had undertaken one or more virtual planning committees.[34] Evidence submitted to the Housing, Communities and Local Government Select Committee suggested that virtual planning meetings had more viewers than typical face-to-face planning meetings[35] and allowed people who would struggle to attend in person to participate,[36] although some respondents worried that they had created a "stale format".[37]

The Food Standards Agency (FSA) allowed local authorities to undertake remote assessments to exchange documents and information about food businesses pre-inspection in July 2020.[38] Local authorities reported that these helped them to reduce officer time on business premises and better target subsequent on-site visits – but did not think that they would be useful to continue after the pandemic, particularly for new and as-yet uninspected businesses.[39]

The other neighbourhood services covered in this report, notably food safety, health and safety, and trading standards, did not shift delivery but instead stopped routine work to respond to coronavirus. At the start of the pandemic, the FSA instructed local authorities to postpone all food hygiene inspections in April 2020, which did not restart until June.[40] Health and safety inspectors issued fewer notices to businesses and spent more time spot-checking businesses, which they were required to do after May 2020.[41]

Some neighbourhood services faced new demands because of the pandemic – although these are likely to be temporary. Trading standards teams, for example, had to verify imported goods in high demand such as PPE and hand sanitiser, and ran communications campaigns to warn people about frauds based on Covid support schemes.[42]

Local authorities diverted staff to the response to Covid pressures during the pandemic

To enforce new regulations,[43] set up new services and rapidly expand existing services for rough sleepers,[44] local authorities hired new staff and redeployed existing staff. By 9 July 2021, the Local Government Association estimated that there were 1% more staff in local authorities in England and Wales compared to 1 March 2020.[45]

Local authorities staffed contact tracing by redeploying existing staff. The FSA report surveyed local authorities about environmental health teams and found that by August 2020 some 46% had transferred at least half of their food safety and hygiene staff,[46] mostly to local contact tracing.[47] This was common across authorities. Birmingham City Council partly staffed its contact tracing team with environmental health officers and the council's call centre;[48] Leicester City Council used customer support and library staff to undertake contact tracing;[49] and Preston City Council trained eight members of its customer service team as contact tracers.[50]

Trading standards staff were also redeployed to support a variety of services from shielding to locally run contact tracing schemes,[51] as were librarians. A quarter of library staff reported being redeployed within their local authority,[52] the vast majority of whom were moved into customer contact roles;[53] heads of library services who responded to a 2020 LibrariesConnect survey confirmed this. In some cases, library staff entirely repurposed libraries, for example as food banks.[54] Staff working in local government services outside the neighbourhood services we cover in this chapter were also redeployed to meet Covid pressures. Employment support officers were moved to adult social care teams to help local authorities recruit additional staff, for example.[55]

Local authorities performed fewer inspections during the pandemic

As a result of lower demand in some services, the impossibility of providing others and staff redeployment, local authorities did less routine activity than normal during the pandemic – particularly in regulatory services.

Health and safety inspectors reported undertaking much less routine work during the pandemic to prioritise inspecting businesses that remained open and enforce Covid regulations.[56] The government set out what it considered priority activities in January 2021,[57] but data on types of health and safety inspections conducted in 2020/21 has yet to be published so we cannot yet judge the size of the potential backlog.* The government has not stated whether any of the temporarily stopped activities could be dropped permanently – or whether it would be effective to do so.

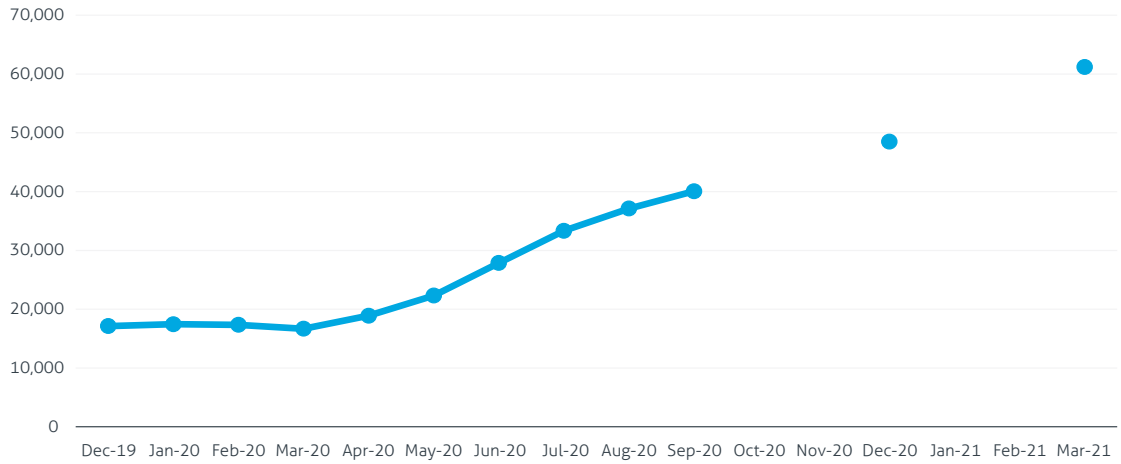
Food safety inspectors undertook far fewer food hygiene inspections. Given staff shortages, local authorities prioritised their most urgent work – responding to complaints and supporting businesses to prepare for the Brexit transition.[58] Inspectors issued just over 30,000 food hygiene ratings – a 1-to-5 assessment of

* The latest available data only covers to 2019/20, Health and Safety Executive, 'LA intervention and enforcement activity', retrieved 14 October 2021, www.hse.gov.uk/lau/enforcement-lae1-returns.htm

hygiene standards in a business – between March 2020 and September 2020, 74% fewer than between March 2019 and September 2019,[59] and inspections remained lower than pre-pandemic levels over the rest of the 2020/21 year.[60]

While restaurants were closed during the first nationwide lockdown, the 'inspection clock' – food businesses have to be regularly reinspected[61] – continued, resulting in large backlogs. The number of food businesses awaiting a food hygiene inspection rating or re-rating almost quadrupled from 16,685 in March 2020 to 61,500 in March 2021.[62]

Figure 5.4 **Number of businesses awaiting food hygiene inspections***



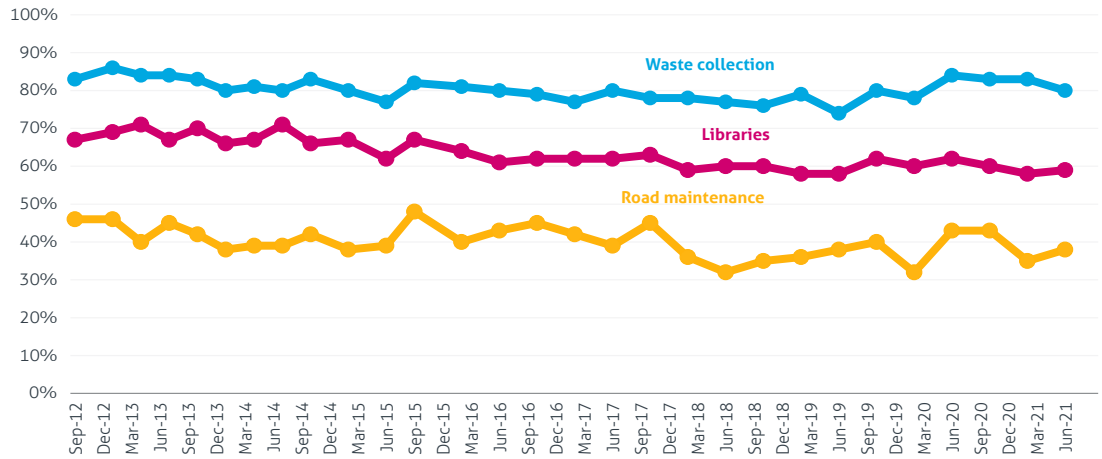
Source: Institute for Government analysis of Food Standards Agency, 'Local authority delivery and performance', Table 3, December 2020; Food Standards Agency, 'Performance and resources report, Q3 & Q4 2020/21'. * The FSA published monthly data until September 2020, after which it began publishing quarterly data.

Deferring inspections may not matter too much in the short term,[63] but in the longer term prolonged deferrals might undermine confidence in the regulatory system – and, of course, consumer safety.[64] The FSA has set out a plan to clear the backlog of food businesses in the top three (of five) food hygiene risk ratings by the end of September 2022,[65] although it relies on returning redeployed staff to routine work,[66] which may not be possible if local authorities have to keep staff deployed in contact tracing teams.[67] The Department for Levelling Up, Housing and Communities (before September 2021, MHCLG) should work with local authorities to collect more information on the extent of potential backlogs in services to inform spending decisions.

Resident satisfaction with local authorities increased during the pandemic

Residents reported being no less satisfied with road maintenance – and marginally more satisfied with waste collection and libraries – in June 2021 than in June 2019, the last equivalent month surveyed before the pandemic. In fact, the quality of roads may actually have increased as local authorities have been able to undertake more maintenance during the pandemic. The Asphalt Industry Alliance estimates that the amount of money required to repair all roads to a good state is slightly lower in 2020/21 than it was in 2019/20,[68] most likely as a result of the greater activity local authorities undertook while traffic levels were lower.

Figure 5.5 **Percentage of residents very or fairly satisfied with their local waste collection, library and road maintenance services**



Source: Institute for Government analysis of Local Government Association, 'Polling on Resident Satisfaction with Councils', Tables A11, A13 and A15.

Due to data limitations, it is harder to judge the outputs and outcomes of the other four neighbourhood services we cover. There was effectively no change in the share of residential and commercial planning applications decided, and the time in which they were decided, between 2019/20 and 2020/21.[69] There were fewer recorded incidents of food poisoning[70] during the pandemic (4,682 in 2020 compared to 8,811 in 2019), although it is unclear if this reflects genuinely fewer cases or more cases going undetected.[71] There is not yet public sector data available on the quality of local authority-maintained roads.*

The longer-term consequences of the reduction in inspections during the pandemic are more concerning. Staff shortages mean that even with additional funding, backlogs in food and health and safety inspections cannot be fixed in the short term. Half of local authorities reported problems recruiting enough qualified food hygiene and food safety staff[72] and the FSA has brought forward planned changes to qualification requirements to widen the pool of staff who can undertake such work. Considering these pressures, the Local Government Association has called on government to either prioritise which inspections it thinks are most important or allow local authorities to determine which inspections to prioritise locally.[73]

* The Department for Transport will publish data on road conditions on 10 November 2021. See Department for Transport, 'Statistics at DfT', retrieved 14 October 2021, www.gov.uk/government/organisations/department-for-transport/about/statistics#forthcoming-publications

How much money will it take to maintain pre-pandemic standards in neighbourhood services?

Projecting the amount of money required for local authorities to maintain standards in neighbourhood services is difficult. Levels of service vary between authorities and demand for each is highly specific. The number of road miles travelled, for example, affects the amount of road maintenance required, and differs between localities. The number of food businesses, and how well they comply with regulations, determines the number of food standards and hygiene inspections. The number and complexity of planning applications affects how much time planning departments need to respond to applications.

To simplify, we assume that demand for neighbourhood services rises in line with the total population of England, using the Office for National Statistics' central projection of a 2% increase between 2020 and 2024.[74] This may in fact slightly overestimate how much local authorities would have to spend, as some services, such as parks and green spaces, are 'non-rivalrous' (one person's use or enjoyment of them is not much affected by others'[*]) and so are less tied to population growth. The IFS estimates that local authority spending on services excluding social care and schools would have been £3.2bn higher in 2024/25 than in 2019/20, although it further assumes that inflation and wage pressures increase costs by an additional 2.1% each year.[75]

Even assuming no cost pressures, local authorities are unlikely to be able to increase spending on these services by 2% each year given the pressures on social care for children and adults, where we project demand will rise much faster. Unless local authorities substantially increase council tax – which they must hold a referendum to do, if increases are greater than a certain percentage[76] – or central government substantially increases local government grants at the spending review, neighbourhood services are likely to face another round of spending pressures as statutory services are prioritised. The IFS estimates that council tax would have to rise by 3.6% each year between 2021/22 and 2024/25 to meet its projection for councils' spending needs, if central government grants rise only in line with all 'unprotected' (as yet unallocated) government spending.[77]

What legacy effects will the coronavirus pandemic leave in neighbourhood services?

In addition to these medium-term pressures, the legacy of the pandemic will place more immediate difficulties on local authorities, largely due to the temporary cessation of some neighbourhood services in the past year. There are known backlogs in food hygiene ratings, and data releases due later in 2021 will almost certainly reveal more in other regulatory services too. The extent of backlogs and unmet need from the pandemic coupled with a decade of spending cuts – and whether they will lead to worse outcomes – is hard to judge due to the lack of available data on reductions in output. While there are more food businesses due for inspection, we do not know if this will result in more incidents of food poisoning later on, for example. Given the lack of data described above, we do not model the cost of possible backlogs, but overall the pandemic is almost certain to increase – rather than decrease – the costs facing local authorities.

[*] Although greater use of parks during the pandemic may have resulted in greater wear and tear and a need to enhance repairs and maintenance.

6. Schools

During the pandemic schools have faced the biggest disruption since at least the Second World War. Schools in England were closed to most pupils for 18 weeks over the 2019–20 and 2020–21 academic years,* equivalent to almost half (44%) of a 39-week school year. Schools were not operating as usual in the 2020 autumn and 2021 summer terms, so many pupils will not have been in school for even longer.

Most pupils did not learn as much remotely as they would have done face-to-face and the gap in reading and maths between advantaged and disadvantaged pupils has grown. At the end of the spring 2021 term, primary school pupils were on average around two months behind in reading and three behind in maths. Even on highly optimistic assumptions about how much learning pupils lost, the government will need to provide more funding than the £3.1bn it has so far committed if it wants to properly address this gap.

This chapter focuses on primary and secondary school pupils aged 5–16 in England. It covers both schools managed by local authorities and academies (which have greater control over admissions, budgets and curriculum), but excludes special schools, pupil referral units, independent schools and 16–18 education such as sixth form.**

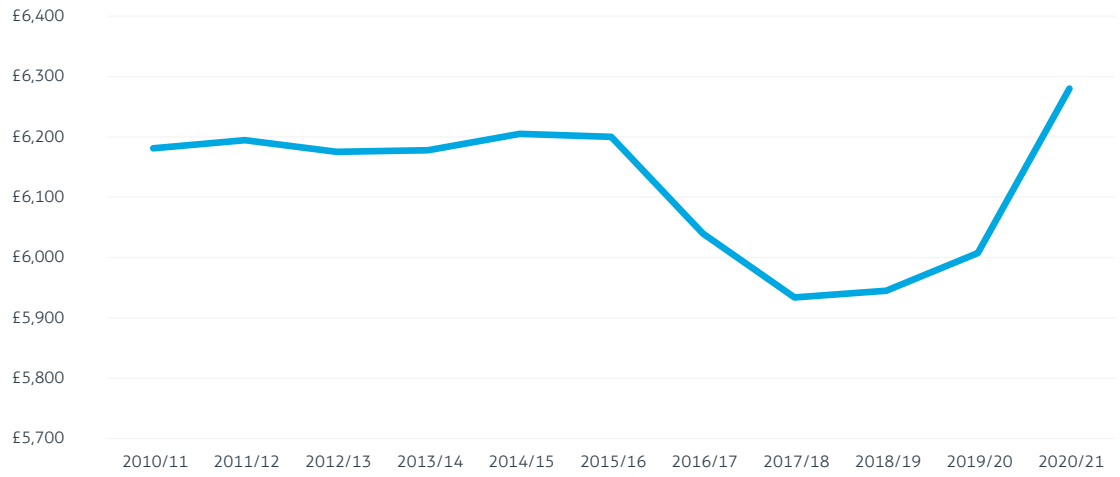
School spending rose during the pandemic – but the government did not cover all additional costs

Cuts to per-pupil school funding had started to slow before the pandemic although this funding did not increase in all schools. At the same time as increasing total funding, Theresa May's government introduced a new national funding formula to better link funding to need and introduce a minimum per-pupil funding level. As a result of these changes and local authority decisions about how to allocate school funding, the balance of funding shifted from more deprived to less deprived schools. The National Audit Office (NAO) calculates that between 2017/18 and 2020/21, average per-pupil funding in the most deprived one fifth of schools fell in real terms by 1.2% – but increased by 2.9% in the least deprived fifth of schools.[1]

* 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.

** We do this because changes in funding in the 2010s and experiences of the pandemic were different for pupils in these schools. There were bigger per-pupil spending cuts on 16–18 education than on spending on pupils aged 5–15. See Britton J, Farquharson C, Sibieta L, Tahir I and Waltmann B, *2020 annual report on education spending in England*, Institute for Fiscal Studies, 2020, p. 93.

Figure 6.1 **School funding per pupil, 2020/21 prices**



Source: Institute for Government analysis of Department for Education, 'School funding statistics, Financial Year 2020/21'.

The Johnson government announced a substantial increase in school funding for pupils aged 5–16 in 2019 and by 2022/23 this increase will bring funding up to the same level, per pupil, as in 2010.[2] School spending would have been higher in 2020/21 than in 2019/20 in the absence of the pandemic, although the crisis has complicated the picture. Schools had to spend to improve infection control (such as deep cleaning, PPE and hand-washing facilities) before the first reopening in September 2020. They also used more supply teachers to cover teachers off sick or self-isolating, and in some cases had to pay for any remote teaching resources not covered by Department for Education (DfE) schemes – such as laptops for children not eligible for the national scheme.[3] But some schools also made savings while they were not open to most pupils, for example, through reduced utilities costs as parts of their buildings were closed.[4]

The government has not yet systematically assessed the impact of the pandemic on school spending[5] as data on maintained (local authority-run) schools' reserves will not be published until December 2021.[6] Academy reserves increased in aggregate between September 2019 and September 2020, suggesting that some schools were able to absorb higher costs at least during the first wave of the pandemic.[7] However, the most detailed survey, from the Education Policy Institute (EPI), suggests that the additional costs of the pandemic were greater than savings, with the net additional cost being on average 1% of annual secondary school spending and 2% of annual primary school spending.[8]

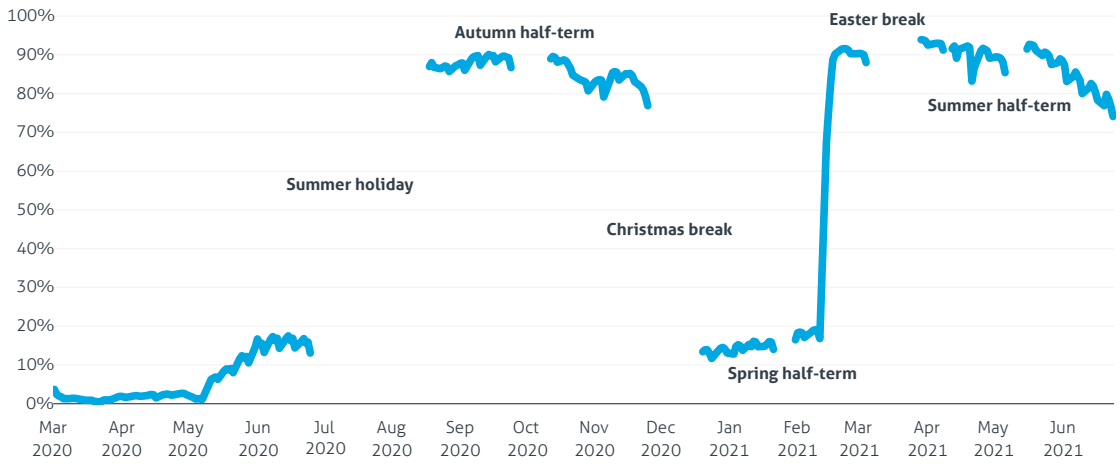
The education department did not reimburse all of schools' Covid costs.[9] Of the £181m schools claimed for costs incurred between March and July 2020, only £139m was distributed,[10] while it also restricted eligibility for funding to schools that were "unable to meet additional costs from existing resources".[11] When including costs that ineligible schools faced, EPI estimates that DfE funding met less than a third (31%) of the costs schools incurred between March and November 2020.[12]

The government reduced schools' costs by delaying the introduction of a higher teacher starting salary of £30,000 until after 2022/23[13,14] – but some schools had to use their reserves to meet the costs of Covid. While some reserves are held to cushion unexpected shocks (though few were likely to cover a shock on the scale of the pandemic) others are earmarked for specific purposes, such as maintenance or decoration.* Schools with the latter type of reserves will have to call off such work, leaving them less prepared for future shocks.

Schools closed for in-person teaching to most pupils for almost half a school year

Schools closed for in-person teaching to most pupils during the first and third England-wide lockdowns. In total, schools did not offer in-person teaching to most pupils for just over 17 weeks between March 2020 and April 2021, equivalent to 44% of a 39-week school year.

Figure 6.2 **Pupil attendance in state-funded schools**



Source: Institute for Government analysis of Department for Education, 'Attendance in education and early years settings during the coronavirus (COVID-19) outbreak', Table 1B and Table 3.

Initially during the first national lockdown, between March and June 2020, few pupils attended school. Attendance then rose from a low of 0.4% to a peak of 3.7% – still well below DfE's expectation that most eligible children (those of key workers, and vulnerable children – roughly 20% of pupils) would attend.[15] School attendance increased slightly from June to July when schools partially reopened, and reached 17.5% of pupils attending in mid-July. Attendance was higher during the third lockdown but still reached a peak of only 19.1% on 3 March 2021.

Teachers continued to set work for pupils while schools were closed for in-person teaching, and some taught lessons remotely. But difficulties in setting up remote learning at the start of lockdown meant that primary and secondary teachers reported working fewer hours than normal in April 2020, although this gradually increased to near-normal hours – 88% of normal hours in primary schools and 84% in secondary

* The Department for Education does not require schools to record what, if anything, they intend to use their reserves for so we cannot say how many schools are in this position.

schools – by June. Parents made up some of the initial shortfall in teacher time by home-schooling, some of which may persist after the pandemic (see below). Teachers responding to TeacherTapp, an app that surveys teachers in England, thought that parents of secondary-aged pupils were involved in 8–9% of teaching and parents of primary-aged pupils involved in up to 30–40% of primary-school teaching[16] during the first lockdown.

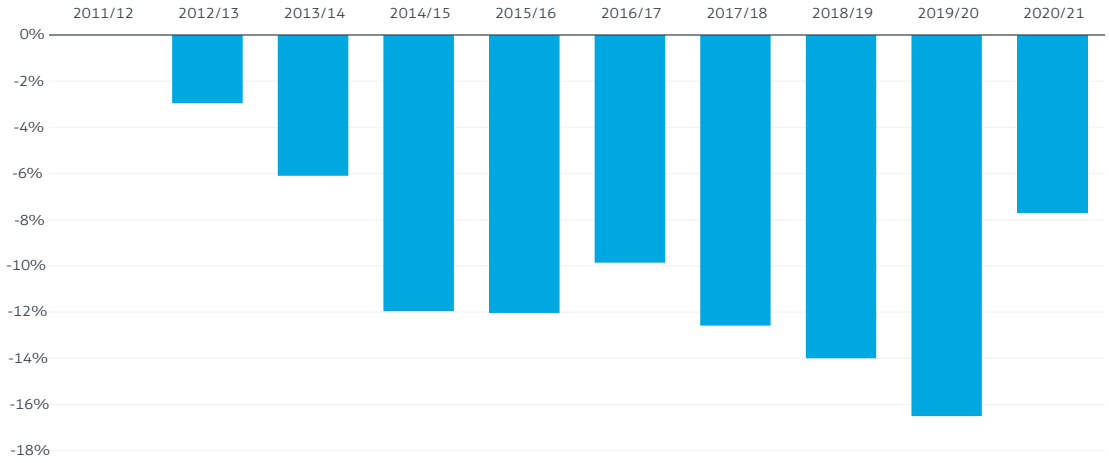
Teacher recruitment and retention increased during the pandemic but this probably will not last

The pandemic was difficult for teachers, as it was for most adults.[17] Teachers' self-reported levels of anxiety rose and life satisfaction fell on average after school closures in March 2020, albeit not in a notably different way to other similar professionals.[18] But head teachers and senior leaders have found managing schools during the pandemic especially difficult. Head teachers reported higher work anxiety than other school staff in the weeks before the first school closure and first school reopening,[19] most likely as a result of having to reorganise teaching and support for vulnerable children. The difficulties head teachers faced were compounded by the high volume of government guidance, most of which was published at the end of the week and for immediate implementation.[20]

Despite these increases in stress and work anxiety, however, teacher recruitment and retention improved as the pandemic reduced other job openings. Only 7.5% of primary teachers and 7.9% of secondary teachers left in 2019–20 school year, compared to 9.0% and 9.4% in 2018–19.[21] A survey of teachers in March 2021 found that the percentage who had considered leaving their job or the profession during the past year had declined by just over 20 percentage points when compared to March 2020, to around 60% and 55% respectively.[22] And while job security may have accounted for fewer teachers leaving the profession (as has been seen in other public services during the pandemic) more people started teacher training. Sixteen per cent more initial teacher training applications were submitted to the Universities and Colleges Admissions Service (UCAS) between November 2019 and September 2020 compared to the period between November 2018 and September 2019.[23]

As a result, DfE got closer to hitting its targets for new trainee teachers – set to ensure enough new trainee teachers are recruited to meet the government's staffing objectives – than it has at any point since 2013–14.[24]

Figure 6.3 **Recruitment to postgraduate initial teacher training, relative to subject targets***



Source: Institute for Government analysis of Department for Education, initial teacher training census, postgraduate ITT new entrants and targets time series by subject. * = We cap recruitment at the target for specific subjects, so over-recruitment in one subject cannot offset under-recruitment in a different subject. Biology, chemistry and physics are counted together to calculate science recruitment against targets in 2011–12 and 2012–13.

Even as the pandemic increased the attractiveness of teaching and other stable public sector jobs, the government still did not hit recruitment targets for subjects that usually prove difficult to recruit for – notably secondary school physics, modern foreign languages, design and technology, chemistry, and maths.

Moreover, the pandemic-era increase in new trainee teachers is unlikely to last. After the 2007/08 financial crisis and ensuing recession, the government hit its overall teacher recruitment targets in subsequent years to 2011/12[25] – but missed all the successive years, when the rest of the economy performed more strongly and pay in the public sector was frozen. In light of this experience, the independent School Teachers' Review Body predicts that extending the 2021/22 pay freeze for teachers would "[risk] a severe negative impact on the competitive position of the teaching profession, jeopardising efforts to attract and retain the high-quality graduates necessary to deliver improved pupil outcomes".[26] DfE's deputy director for the teacher workforce has said that the department expects the increase in applications to be "short-lived".[27] Applications have indeed started to fall back to normal levels. Since June 2021, the number of new monthly initial teacher training applications fell below the number of applications in the pre-pandemic school years of 2017–18 and 2018–19.[28]

In fact, the pandemic is likely to reduce teacher retention in the longer term given the pressures teachers have experienced during the past year. In a January 2021 survey, teachers said that they were more likely to leave teaching in the future as a result of the pandemic. Just over 21% of teachers reported that they intended to leave by this summer, compared to 11% of teachers before the pandemic[29] – although some of these teachers may have intended to leave sooner, but chose not to during the pandemic.

Concerningly, one of the biggest increases in leaving intentions was among senior leaders. This replicates findings from a June 2020 survey, which found that 20% of head teachers said the pandemic had made them more likely to leave the profession – double the 10% of classroom teachers and middle leaders who said that the pandemic had made them more likely to leave.[30]

The increase in teacher starting salaries to £30,000 by the end of this parliament[31] should help boost recruitment – but this is unlikely to help retain more experienced teachers, whose pay did not increase as quickly as less experienced teachers after 2017.[32] The real shortfall, if one occurs, is more likely to be from experienced staff leaving rather than from too few new teachers being recruited. The government will need to focus on improving retention, particularly on teacher workload – which has been a big problem over the last decade[33] – to mitigate the impact of the pandemic.

Schools were unable to teach pupils to the same standards in the past two academic years

Most pupils took part in remote learning while schools were shut, but did not receive as much teaching this way as when in school. Pupils typically spent 5–6 hours in school each day before lockdown, including breaks,[34] which was higher than almost any reliable estimate of how much pupils learnt at home, during the first lockdown at least.

A 2020 survey of parents using the UK Household Longitudinal Study found that children spent only 2.5 hours each day doing schoolwork.[35] Separately, an Institute for Fiscal Studies survey of parents more optimistically found that, on average, primary and secondary pupils spent five hours per day learning – although this is likely to be an overestimate. A TeacherTapp survey of teachers found that most teachers thought remote pupils were working for fewer than two hours each day, on average.[36] All surveys found that, on average, pupils spent fewer hours studying during the first lockdown than they did in school[37] – but some pupils learnt much more, and much less, than others. According to parents' records of how much time their children spent on schoolwork during the first national lockdown, almost one fifth reported their children spending an hour or less per day on schoolwork.[38]

Even when schools reopened to all pupils for in-person teaching, social distancing measures such as staggered start times and changes to the school timetable reduced the amount of time pupils spent learning each day. Schools prioritised providing support for pupils' emotional health and wellbeing rather than academic catch-up or normal curriculum teaching at the start of the 2020 autumn term.[39] In the second half of that term, primary schools in particular adapted the curriculum to focus more on English and maths.[40] When combined with pupils absent due to Covid, four in 10 pupils still did not receive a full school day[41] in the autumn 2020 term – and even by the summer 2021 term school leaders worried that social distancing measures were still reducing the quality of teaching and learning.[42] Consequently, most pupils did not cover as much curriculum content as they normally would have.

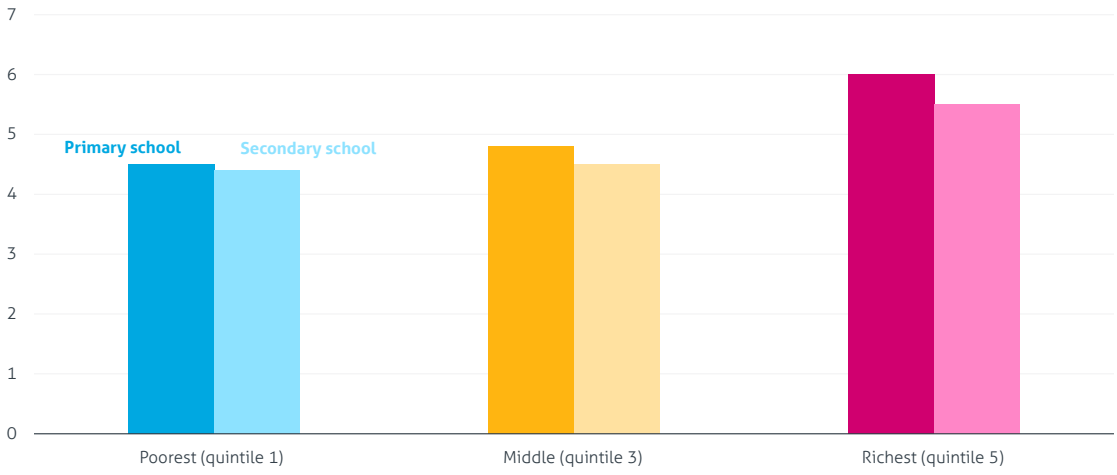
The Office for National Statistics estimates that remote learners covered between half and three quarters of the curriculum that in-person pupils did between September and December 2020[43] (who themselves were covering less of the curriculum than normal).

There was wide variation in how much education and support schools provided to children during the pandemic,[44] but overall the reduction in the quantity and quality of learning was due to the nature of remote learning itself. There have been losses in attainment globally[45] and even in countries that were well placed to respond to school closures, there were notable falls in attainment. In the Netherlands, which closed schools for only eight weeks and has high levels of broadband access, pupils appear to have learnt almost nothing at home. Comparing before and after the closures, the decline in pupil attainment was roughly equivalent to the amount of time schools had been closed.[46]

The pandemic exposed and widened socioeconomic differences

The reduction in learning times was highly unequal. During the first lockdown, primary and secondary pupils in the poorest fifth of households reported spending almost two hours fewer per day learning than pupils in the richest fifth of households.

Figure 6.4 **Children's daily learning time in April–May 2020 (hours)**



Source: Institute for Government analysis of Institute for Fiscal Studies, *Learning During the Lockdown*, underlying data, Figure 2.

The type of learning children did at home also differed. Children in the richest quintile had a higher quality, as well as quantity, of learning. They reported spending much more time with a private tutor, in online classes and on other schoolwork.[47] Pupils in private schools reported having considerably more live lessons.[48] When comparatively less access to computers or tablets, dedicated study spaces and parental support are taken into account,[49] poorer pupils unquestionably learnt far less than richer pupils.

There is some evidence that remote learning was more effective during the second national school closures. Comparing surveys of parents during the first and second England-wide closures, the Sutton Trust, an education charity that advocates for social mobility, found that the proportion of secondary school pupils studying for at least

five hours per day increased to 45% in January 2021, up from 19% in April 2020 (the increase in primary school children was 11% to 23% in the same period).[50] The government set minimum standards for the amount of remote teaching schools should provide in January 2021,[51] which may explain the higher reported rate during the second England-wide school closures.

Nonetheless, the difference in the time that children from the poorest and richest households spent studying remained. In January 2021, 40% of pupils from middle-class families – where parents worked in occupations grades ABC1 (managerial, administrative and professional work) – spent at least five hours per day learning compared to just 26% of pupils from working-class families – where parents worked in occupation grades C2DE (manual work, casual work or unemployment). When looking at the type of school, teachers in private schools were more than twice as likely to say that their pupils were studying for at least five hours per day (64%) compared to teachers in state schools (30%).[52] Within state schools, teachers continued to report disadvantaged pupils having less IT access and returning less work.[53]

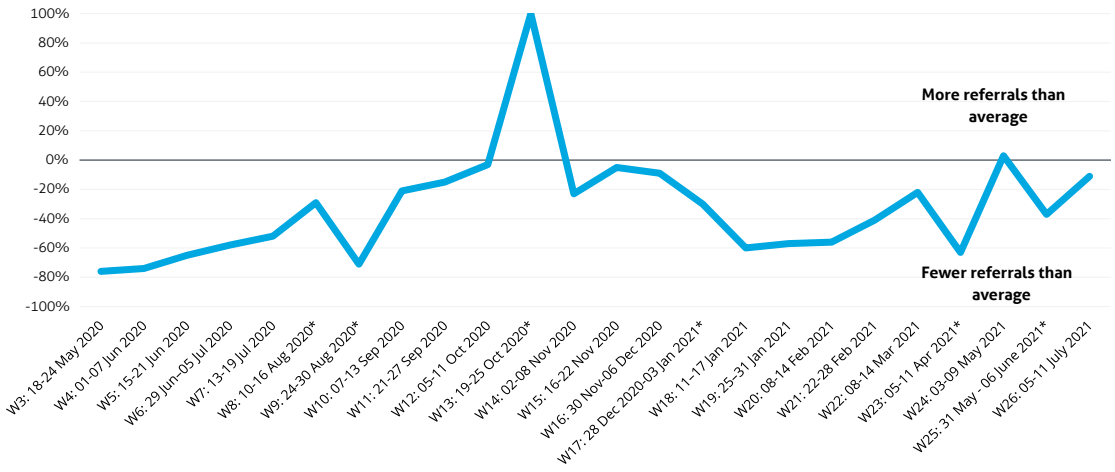
The limited evidence we have suggests that the expansion of inequality was not the result of school failures. Schools tried a range of strategies to stop the attainment gap expanding during remote and hybrid teaching – from contacting disadvantaged pupils' parents to streaming live lessons and reducing the curriculum to focus more on English and maths – but there is no evidence that these helped to reduce the attainment gap. An Education Endowment Foundation study found no clear link between various school responses to the pandemic and changes in school-level attainment gaps.[54]

Schools have been less able to supervise at-risk pupils

Teaching children is not the only thing schools do. They also provide careers advice, extra-curricular activities and support for vulnerable children – all of which have become harder remotely. This is clearest in the referrals teachers made to children's social care services. In normal years teachers are responsible for just under 20% of all referrals to children's social care; between April 2019 and March 2020 teachers made 117,010 such referrals.[55] During the pandemic, however, teachers referred far fewer pupils than normal – even after schools reopened in-person teaching to all pupils in September 2020 and March 2021.[56]

The drop is surprising given that there has been an increase in the number of children at risk of physical or mental harm during the pandemic (see children's social care chapter). Children's reported mental health declined during the pandemic[57] due to increasing strain on family relationships, academic stress and reductions in access to mental health support.[58] Schools and socialising with other children are normally one way to ameliorate these pressures – but most children have had far fewer opportunities for this. One study compared the mental wellbeing of primary school children in England who were and were not allowed to return to school at the end of 2020 summer term (exploiting the fact that only reception, year 1 and year 6 pupils returned). This found that children who did not return had more behavioural and emotional difficulties.[59]

Figure 6.5 **School referrals to children's social care compared to average referrals, compared to 2017–20 average**



Source: Institute for Government analysis of Department for Education, 'Vulnerable children and young people survey', Table 2. * = Comparisons to usual levels during school holidays should be treated with caution as the timing of school holidays varies from year to year.

The pandemic may also cause some pupils to drop out of the school system entirely. Some parents withdrew their children from schools during the pandemic, even after they were reopened. The Local Government Association found that elective home education registrations[60] – where a parent informs their local authority that they intend to educate their child at home – increased in September 2020 compared to September 2019. Parents do not have to tell local authorities that they intend to educate their children at home, so this increase will be an underestimate.

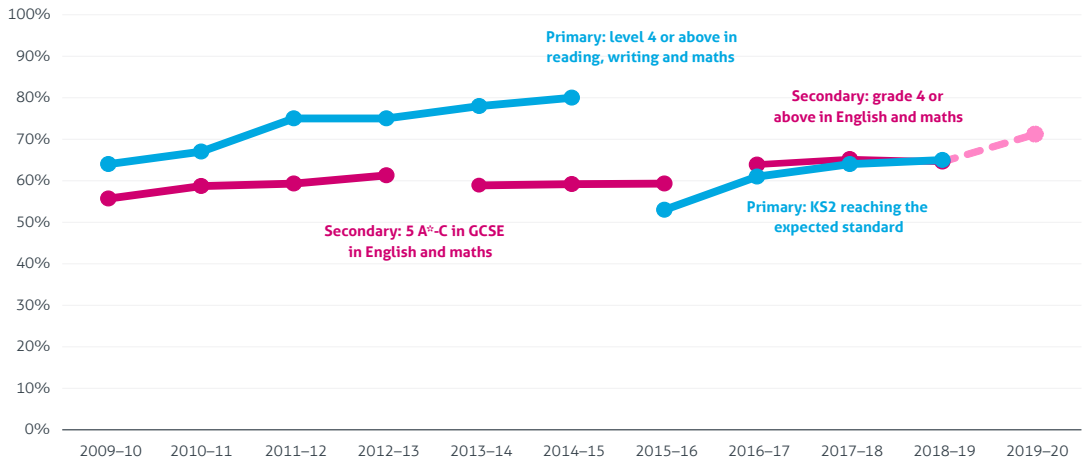
On top of this, it is hard to estimate the true figure as there are no definitive figures on the number of children educated at home, before and after the pandemic.[61] Looking at absence data in autumn 2020, the Children's Commissioner for England estimated that there was a 1–2% rise in 'unexplained absence' – between 120,000 and 200,000 more pupils absent from school compared to 2019 (whose absence could not be explained by Covid).[62] Not all of these absences will be permanent – some parents have told schools that they intend to return their children "once the pandemic is over"[63] – but it raises concerns that some children have fallen out of the formal school system entirely.

Exam results rose but children lost valuable lesson time

National school closures resulted in widespread concerns about lost learning and falls in attainment, although this was not reflected in 2020 or 2021 exam results, which were notably higher in 2020 compared to 2019.

Following a government U-turn in August,[64] pupils were given their centre-assessed grades if they were higher than the standardised grades originally received from qual, resulting in substantial overall grade inflation.* The proportion of secondary school pupils achieving grades 4 or above in English and maths rose from 65% to 71% between 2019 and 2020, and this rose again in 2021[65] when results were allocated as teacher-assessed grades.[66]

Figure 6.6 **Pupil attainment at the end of primary (key stage 2) and secondary (key stage 4)**



Source: Institute for Government analysis of Department for Education, 'GCSE and equivalent results'.

There were no good options for grading in 2020 and 2021.[67] Any decision would have meant that 'exam results' – given that pupils had had a disrupted year and exams were not taken – were not a reliable indicator of attainment.

In the absence of exam data comparable to previous years, researchers have used standardised school assessments to estimate how much learning pupils have lost. These studies – comparing assessment results either between 'pandemic pupils' (whose education was disrupted by Covid) and pupils in previous years, or between pandemic pupils' scores and what they would have been expected to achieve without the pandemic – show falls in English and maths attainment among primary and secondary children, with the largest losses among the youngest pupils.

* Rising grades do not necessarily imply grade inflation, but it is extremely unlikely that pupils genuinely learnt and achieved more in the 2019–20 school year. The results of the National Reference Test – which has been used to baseline exam results since 2017, and which pupils sat in February 2020 before school closures – showed that the 2020 exam cohort were roughly on track for similar grades as the 2019 cohort before school closures. See: Burge B and Benson L, *National Reference Test Results Digest 2020*, National Foundation for Educational Research, 2020, pp. 12–17.

The eight robust studies of the coronavirus pandemic on pupil attainment in England[68] to date have shown that there were falls in attainment equivalent to 1–3 months of learning by the start of the 2020 autumn term.* While there was some catch-up while pupils were back in school in autumn,[69] pupils fell further behind during the second national school closures. By the start of the 2021 spring term, primary school pupils were around two months behind expected progress in reading, and between three and four months behind expected progress in maths.[70]

Where measurable, the declines in attainment were larger among disadvantaged pupils: seven of the eight studies in England that analysed the impact across different groups found that disadvantaged pupils had greater learning losses.** Three of the studies also found differences between pupils in different regions. The Education Policy Institute and Renaissance Learning found slightly larger maths and reading learning loss among pupils in the North East and Yorkshire and the Humber than in other regions,[71] although regional differences were not consistent between the studies. The evidence on differences in learning loss between pupils in different parts of the country is so far mixed.

In the longer term, international tests will better expose the impact of the pandemic on pupil attainment. The upcoming 2021 Progress in International Reading Literacy,[72] 2022 Programme for International Student Assessment[73] and 2023 Trends in International Maths and Science Study[74] will show how pupils whose education was disrupted by the pandemic perform compared to pupils of the same age in previous years.

How much would schools have to spend to maintain pre-pandemic standards?

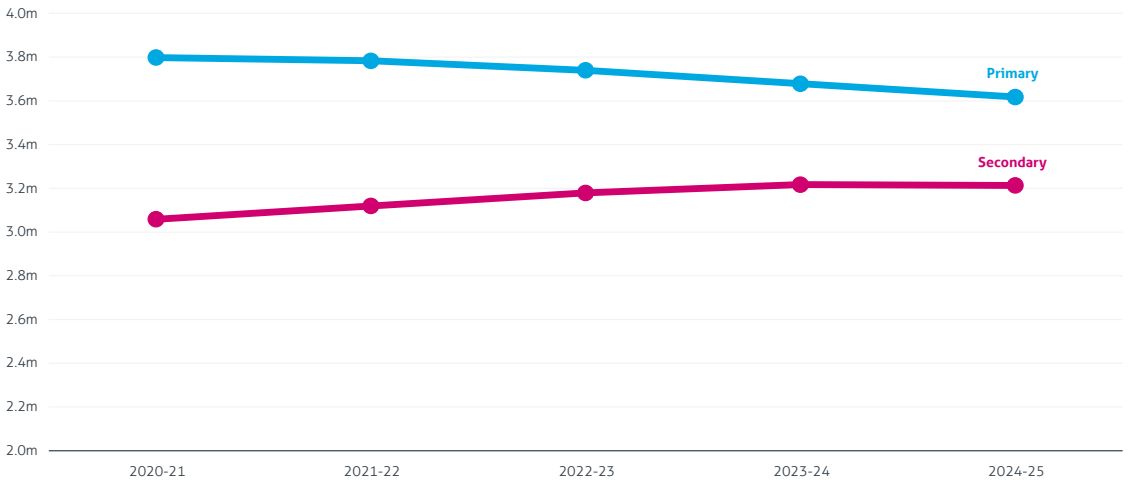
The number of school-aged children is projected to fall during the rest of the parliament in line with wider demographic factors in England. At the same time, school costs will probably rise because the government is likely to increase teacher pay in real terms (faster than economy-wide inflation). The three-year school funding settlement the Johnson government set out in September 2019 will bring school funding up to around the same level, per pupil, as in 2010, although rising school costs will mean that money will not be able to employ as many teachers as now.

DfE projects that the number of primary school pupils will fall by 5.1% between 2019–20 and 2024–25, while the number of secondary school pupils will increase by 7.4%. There are currently more primary pupils than secondary pupils, so the total number of pupils will increase by 0.4% between 2019–20 and 2024–25.[75]

* One study reported a null finding of a small but not statistically-detectable decline in primary school reading.

** The various reports measure disadvantage in different ways, looking at either disadvantaged pupils (those in receipt of free school meals, pupils eligible for pupil premium) or disadvantaged schools (measured by postcode-level deprivation or proportion of school children eligible for free school meals).

Figure 6.7 **Projection for state-funded school pupils in England**



Source: Institute for Government analysis of Department for Education, 'National pupil projections', July 2021.

When coupled with the 2019 three-year school funding settlement, per-pupil school funding should rise 9% in real terms between 2019/20 and 2022/23.[76] If the government chooses to hold per-pupil funding constant in real terms over the rest of the parliament, then it could reduce schools budgets by 0.3% in real terms between 2022/23 and 2023/24 as the reduction in the number of primary pupils outweighs the increase in secondary pupils in that final year.

The government would have to spend 0.9% more in real terms in 2024/25 than it did in 2019/20 to continue providing the same scope and quality of learning to rising numbers of pupils, although schools costs may rise faster. Schools face some unavoidable additional cost pressures over the next few years, such as higher teacher starting salaries (which the government has pledged to increase to £30,000 by the end of the parliament) and increases in their contributions to teachers' pensions schemes.*

School costs were already increasing faster than economy-wide inflation, as measured by the GDP deflator, between the 2015 spending review and the pandemic. DfE estimates that cost pressures on mainstream schools exceeded funding increases by £2.2bn between 2015/16 and 2019/20, mainly because of rising teacher staff costs.[77] Owing to pay rises agreed in July 2020 to start from September 2020 and further increases in schools' contributions to teachers' pensions – which was covered by the teachers' pension employer contribution grant – the department expects that teacher costs will increase faster than economy-wide inflation between 2019/20 and 2020/21.[78]

* The government gave schools money to cover these costs in the 2019–20 and 2020–21 school years through the teachers' pension employer contribution grant, but it is not clear how these costs will be funded in the 2021–22 school year as the grant is being rolled into the central schools grant. See: Department for Education, 'Pension grants for schools, local authorities and music education hubs', GOV.UK, 17 February 2021, retrieved 26 September 2021, www.gov.uk/government/publications/teachers-pension-employer-contribution-grant-tpecg/pension-grant-methodology

The government has yet to make decisions about teacher pay (other than starting salaries) beyond 2021/22.[79] But if teacher pay and school pension contributions continue to rise faster than economy-wide inflation, then cost pressures will increase further. After more than a decade of limited growth in teacher pay[80] a pay freeze after 2021/22 would result in teacher pay falling behind comparable private sector jobs and make it extremely challenging to retain enough teachers in schools. Taking account of school cost pressures and the government's existing spending plans, the Institute for Fiscal Studies estimates that if teacher pay grows by 3% per year, other staff pay grows by economy-wide average earnings growth and non-staff costs grow in line with economy-wide inflation, then real school spending per pupil (adjusted for school-specific inflation) would not return to, and would be 3% below, 2009/10 levels in 2022/23.[81]

How much would it cost to address the legacy of the pandemic in schools?

School closures have prompted widespread concern about lost learning, children's socio-emotional development and long-run effects on lifetime earnings.[82] The IFS estimates that loss in lifetime earnings as a result of school closures could be up to £350bn for the cohorts affected.[83] In response, the government appointed Sir Kevan Collins as its 'education recovery commissioner' in February 2021[84] to "advise on the design and implementation of potential interventions that will help students catch up learning lost due to the pandemic".[85] He originally proposed a package of £15bn between 2021/22 and 2023/24[86] but the government rejected this[87] and instead allocated just £1.4bn for the 2021/22 school year;[88] funding for future years will be decided in the spending review. Collins resigned in protest in June.

In total, the government has so far for England provided £3.1bn for tutoring, summer schools and other recovery activities[89] between 2020/21 and 2024/25.[90] This is less, per pupil, than Wales has allocated for 2020/21 and 2021/22[91] and is unlikely to be enough to ameliorate lost learning. Giving evidence to the Education Select Committee, Collins criticised the government's existing package as "a bit feeble [in light of] this scale of shock".[92] The Office for Budget Responsibility also estimates that the existing package is insufficient, and that the government would have to spend at least £1bn more each year between 2021/22 and 2023/24 to help pupils recover two months' lost learning[93] – a conservative estimate of how much learning pupils lost during the pandemic.

The cost of helping pupils catch up to where they would have been without the pandemic depends on how much learning and emotional development has been lost and how much pupils might recover without support. Some may catch up without additional support. During the autumn term, which was heavily disrupted by Covid and before most catch-up schemes had started, some caught up on reading and maths. Between the start and end of the 2020 autumn term, on average, primary school pupils moved from having lost 1.8 months of reading and 3.7 months of maths to 1.2 and 2.6 months respectively.[94] Secondary school pupils also appear to have caught up on maths and English in the same time period, although small sample sizes mean we do not know whether they made progress over the autumn term.[95]

Even if pupils might make progress on maths and reading attainment without catch-up schemes, there may be wider losses in social and emotional development that are harder to measure. Indeed, school leaders surveyed by the National Foundation for Educational Research worried that the government's existing plans focused too heavily on academic tutoring at the expense of pupils' wellbeing.[96]

To provide an indication of how much schools might need to spend to catch up, we set out three scenarios to benchmark the government's spending plans against potential need: a low scenario where pupils learnt 80% as much as they would have done if schools had been open, a central scenario where they learnt 50% as much, and a high scenario where they learnt only 30% as much. The low scenario implies that pupils are just over a month behind, the central scenario 3–4 months behind, and the high scenario five months behind.

We estimate that schools would require an additional £3.8bn to help pupils catch up in the low scenario, £13.2bn in the central scenario, and £18.9bn in the high scenario (see Methodology). All three scenarios are more than the £3.1bn the government has allocated so far – but in practice the cost is likely to be closer to the central or high scenario. The most recent evidence about the scale of learning loss in England in the 2021 spring term implies that primary pupils were 2–2.3 months behind in reading, and 3.1–3.6 months behind in maths.[97]

In theory, school catch-up schemes are a one-off cost to help children who have missed out on in-person learning – but in practice the measures may be extended if they prove to be effective.[98] If extensions to the school day and additional tutoring for disadvantaged pupils work well and help achieve government goals, such as reducing the education disadvantage gap,[99] then there would be a strong case – and potentially a strong school and parental lobby – to keep these schemes such as a longer school day or additional tuition permanently.

7. Police

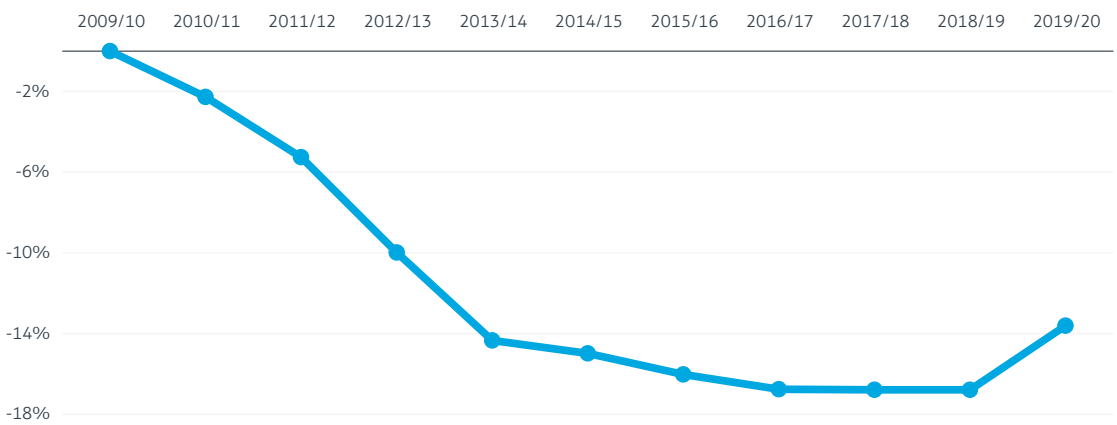
The police played an important role in the coronavirus response, taking on welfare as well as enforcement duties, such as liaising with families who had lost loved ones. Crime fell during the first lockdown but from June 2020, when crime rates began to increase again, the police had to balance their new responsibilities with day-to-day policing. Many officers worked overtime and reported fatigue as a result.

Despite this, retention and recruitment have improved, and the government is on track to hit its recruitment target of 20,000 more officers by 2023. Remarkably, some performance indicators – including public satisfaction and charging rates – also improved this year.

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. In normal years, the police respond to crimes, conduct prevention work (such as patrolling and gathering intelligence), respond to mental health incidents, traffic accidents and missing persons, and help safeguard vulnerable people. During the pandemic, police forces have also had to enforce the government's coronavirus regulations. We cover all the police roles in this chapter.

Central government spending on the police had started to rise before the pandemic and is likely to continue to rise

Figure 7.1 **Change in gross police spending in England and Wales since 2009/10**



Source: Institute for Government analysis of Ministry of Housing, Communities and Local Government, 'Local authority revenue expenditure and financing in England' and 'General fund revenue account: police outturn'; StatsWales, 'Revenue outturn expenditure summary', 2009/10–2019/20.

Police in England and Wales receive funding from several sources. The majority of funding comes from the government and is known as the police funding settlement. Around one third of funding is raised through the 'police precept', which is a council tax levy. The police precept is set by local Police and Crime Commissioners (PCCs). However, the Ministry of Housing, Communities and Local Government (MHCLG) sets referendum limits each year that determine the level of increase above which a local referendum must be held. Police forces also receive income from policing events such as sporting events and concerts.

Before the pandemic, the government had begun to reverse police spending cuts and announced substantial increases in police funding. In 2019/20 it spent £14.2bn on policing in England and Wales; 3.8% more in real terms than in 2018/19.[1]

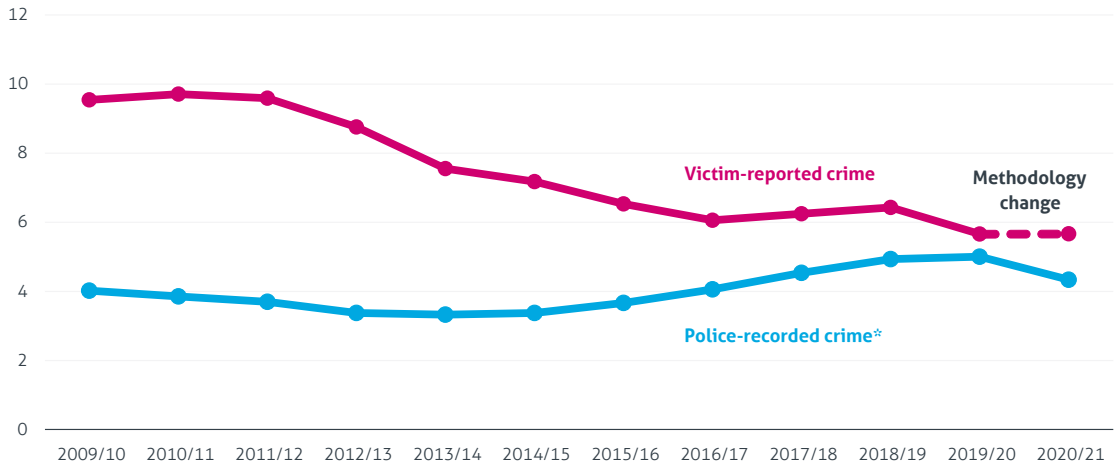
Spending on the police would probably have continued to rise even if the pandemic had not happened, as the government had committed £700m to recruit 6,000 officers by March 2021 in the 2020/21 funding settlement,[2] and £400m for the police uplift programme in 2021/22.[3]

The pandemic has resulted in some additional costs for the police. The biggest was staff overtime as the police enforced Covid regulations while many officers had to self-isolate,[4] although forces have also spent money on personal protective equipment (PPE), information and communications technology, such as purchasing laptops and software licences to enable home-working, and making police stations Covid-secure.[5] The government made £58m available to help forces to meet these costs,[6] and reimbursed forces for all additional PPE purchased between March and July 2020.

The pandemic may lead to reductions in police funding in the medium term, however, as local voters may be unlikely to vote for higher spending when council taxes are already set to increase.[7,8]

The overall level of crime fell during the pandemic but incidents of fraud rose rapidly

Figure 7.2 **Total annual incidents of crime in England and Wales, excluding fraud and computer misuse (millions)**



Source: Institute for Government analysis of Office for National Statistics (ONS), 'Crime in England and Wales: Appendix tables', Table A1 and Table A2; and ONS, 'Recorded crime data at Police Force Area level', 2009/10–2020/21. * = Police-recorded crime figures exclude those from the Greater Manchester police force, 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. A police inspectorate report found the force actually failed to record 80,000 crimes in the year to December, partly due to this system. See HM Inspectorate of Constabulary and Fire and Rescue Services, 'Greater Manchester Police: An inspection of the service provided to victims of crime by Greater Manchester Police', December 2020, www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/an-inspection-of-the-service-provided-to-victims-of-crime-by-greater-manchester-police.pdf; HM Inspectorate of Constabulary and Fire and Rescue Services, 'Greater Manchester Police integrated Operational Policing System (iOPS): An inspection to review the force's action plan to reduce backlogs arising from the implementation of a new computer system', 3 March 2020, www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/greater-manchester-police-integrated-operational-policing-system.pdf

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). Police-recorded crime excluding fraud fell in 2020, breaking the rising trend seen since 2014/15. Incidents of fraud, however, rose during the pandemic.

In 2020/21, the police recorded 4,336,643 crimes, excluding fraud; 13% fewer than in 2019/20. This is largely due to a decline in theft, which fell 33% this year, from 1,811,838 incidents in 2019/20 to 1,223,639 in 2020/21.* Theft decreased because people remained at home for longer periods during the pandemic, making it harder to burgle properties or steal cars.[9] Sexual offences also fell by 10%, criminal damage and arson by 16% and possession of weapons by 6%.[10]

* Figures exclude incidents recorded by Greater Manchester Police.

The level of victim-reported crime mostly corroborates this picture.* Victim-reported thefts and robberies dropped by 342,000 incidents, although victim-reported violence rose by 335,000 incidents; a 27% increase on 2019/20.[11] The majority of violence is non-domestic. However, incidents of domestic violence rose at a much faster rate than non-domestic violence during the pandemic. There were 85% more incidents of domestic violence between May 2020 and March 2021 (the period over which interviews for the CSEW took place this year), compared to 2019/20 – while violence committed by a stranger increased by just 2% over the same period.[12] Charities have reported a global rise in domestic violence during periods of lockdown, as for those with abusive partners, staying at home meant there was more chance for violence to occur.[13] The government allocated £25m to domestic abuse services in May 2020 in response to this spike, and the Home Office provided an extra £683,000 in November 2020 to help victims of domestic violence.[14]

Other crimes also rose during the pandemic. Police-recorded data shows that public order offences were 5% higher in 2020/21 than 2019/20, and drug offences were 14% higher. Public order offences rose as breaches of social distancing regulations created a new type of offence for police to target. The increase in recorded drug offences reflects improvements in policing as much as more offences. It has been easier for the police to identify dealers with fewer people on the streets,[15] and some forces ran proactive operations around drugs and county lines during the first lockdown.

There has been a particularly large increase in incidents of fraud and computer misuse during the pandemic as people have spent more time online. Coronavirus has provided an opportunity for scammers, with incidents related to furlough, PPE and vaccine trials.[16,17] Action Fraud, the organisation responsible for recording fraud and computer misuse offences on behalf of individual police forces, recorded 837,104 incidents of fraud and computer misuse in 2020/21[18] – 8% more than in 2019 – however, the actual fraud rates may be much higher. The CSEW showed there were 6,388,000 incidents of fraud and computer misuse reported between May 2020 and March 2021, compared to 4,551,000 in 2019/20.[19] Fraud was rising before the pandemic struck: between 2011/12 and 2020/21, police-recorded incidents of fraud and computer misuse rose by 76%, and fraud may rise further after the pandemic as criminals use the expertise they have built in online fraud to target more people.

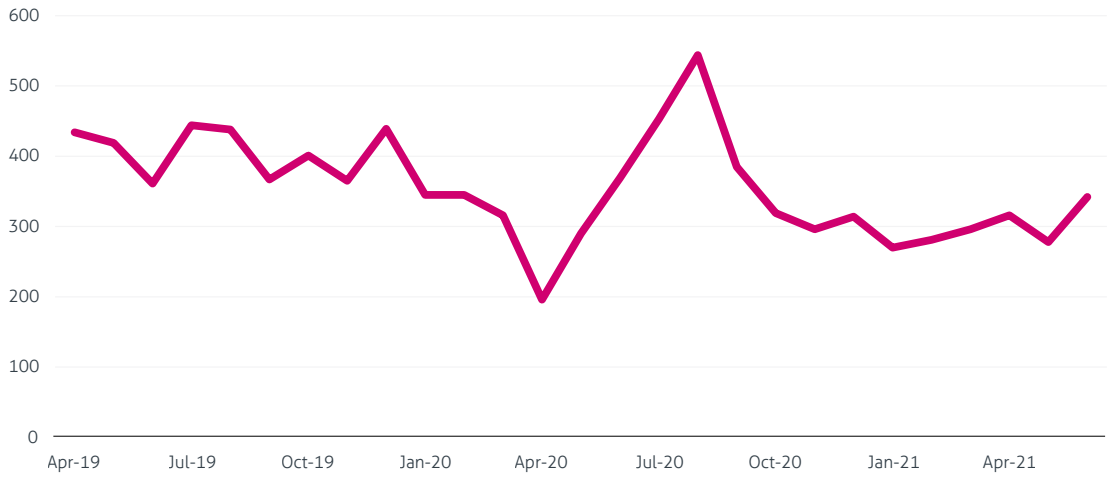
Despite the rise in fraud, there is a large disparity between fraud offences and resources available to address it. In 2020/21, there were just 1,618 police personnel involved in fraud investigations; less than 1% of the police workforce.[20] Fraud investigations are often long and complex, and can require a number of investigators working across force borders, which worsens resource shortages. As a result, the majority of forces use generalist investigation teams to deal with fraud cases – but generalist officers lack the skills to investigate fraud effectively.[21] When surveyed in 2018, 78% of officers surveyed reported that they needed more training to deal with fraud cases, while 86% thought fraud should be tackled by specialists.[22]

* This may be a less reliable indicator of changes to crime, though, as Covid restrictions altered the way in which the survey was conducted this year. Normally around 30,000 households take part and interviews are conducted in person. This year, a shorter version of the survey was conducted over the phone, and there were fewer participants. This may have affected how willing respondents were to report crimes.

However, attracting those specialists is difficult. A third of police force leads are not confident they can recruit the right staff to address fraud, and a quarter are uncertain whether they could retain these staff because fraud investigators are often lost to other sectors.[23] There is also debate about whether staff should be located in the lead force (City of London Police) or local forces. This lack of staff predated the pandemic, but the rise in online crime that occurred during Covid has worsened the imbalance between offences committed and resources available. If the government wants to tackle rising fraud, it will need to recruit more non-warranted police investigators and consider pay and career pathways for these investigators (the uplift programme currently focuses on police officers).[24]

When lockdown restrictions were lifted, knife crime rose to levels higher than those seen before the pandemic

Figure 7.3 **Number of hospital admissions for assault by sharp object, April 2019 to June 2021**



Source: Institute for Government analysis of NHS Digital, 'Monthly hospital admissions for assault by sharp object', April 2019–June 2021.

While total levels of crime fell during the past year, there were spikes around the easing of lockdown restrictions,[25] which was particularly evident in knife crime. The total number of offences recorded by police involving a knife fell 15% in 2020/21 compared to 2019/20.[26] The number of people admitted to hospital for assaults by a sharp object show that knife crime fell markedly during the first lockdown. There were just 196 admissions to hospitals in England and Wales for assault by a sharp object in April 2020; 55% fewer than in April 2019. However, when restrictions were eased, levels of knife crime soared and in August there were 544 admissions, the highest monthly number recorded since data collection began in April 2012. The increase was particularly high in the areas covered by the Metropolitan (the Met), Greater Manchester, West Yorkshire and West Midlands police forces.

Criminologists had warned this may happen as gang rivalries built up during lockdown, when some gangs expanded their county lines drugs operations by seizing the territory of rivals who complied with stay-at-home orders.[27] Gangs were also able to target vulnerable children while schools and youth services were closed,[28,29] and youth

workers have warned that those teenagers who do not return to full-time education or after-school activities will be vulnerable to grooming in the future,[30] which could lead to higher levels of crime. If this happens, the government may need to divert resources to address the causes of knife and gang-related crime after the pandemic.

Police officers have undertaken additional enforcement and support work during the pandemic

Variation in crime rates affected police activity. The decline in crime during the first lockdown gave forces an opportunity to target known criminals. For example, the Met formed new violence suppression units to address 250 of London's most violent neighbourhoods,[31] and ran more proactive drugs operations during this period.[32] The police also spent more time on incidents that do not relate to crime, such as responding to people in a mental health crisis. Difficulties providing social care for children and adults during the pandemic increased the demand on police time.[33]

At the same time, some officers acquired extra Covid-related duties. When surveyed by the Police Federation between October and November 2020, 28% of officers reported having undertaken specific Covid-related responsibilities.* Much of this work involved enforcing regulations: between 27 March 2020 and 14 March 2021, police forces in England and Wales issued 94,368 fixed penalty notices for breaches of lockdown regulations.[34] Officers also reported attending suspected Covid deaths, issuing death notices and carrying out welfare checks on Covid-positive patients.[35] In addition, the police have managed custody and remote court appearances in police cells, which was previously managed within the courts.[36]

These duties have continued throughout the pandemic, but rising crime rates over the summer months, in addition to an increasing number of protests, put strain on the police as they found themselves balancing Covid enforcement with day-to-day policing work once more. By the end of 2020, however, Covid-related duties had become less of a priority.[37]

During the past year, police forces have also adapted their ways of working by making use of new technology. Some forces, such as Humberside, have conducted safeguarding meetings virtually. This has led to increased attendance of partner agencies, better information exchange and more informed decision making,[38] although families participating in child protection conferences, in particular, have not found online calls as beneficial (as described in the children's social care chapter). Forces have also taken witness statements over the phone, which they say has been a more efficient use of police time, and there has been an increase in the level of digital transfer of evidence from police to the Crown Prosecution Service (CPS).[39] Both of these changes are likely to continue.

* This figure may actually be higher, as the federation received feedback that many on the front line simply did not have time to complete the survey this year.

Police recruitment and retention increased during the pandemic

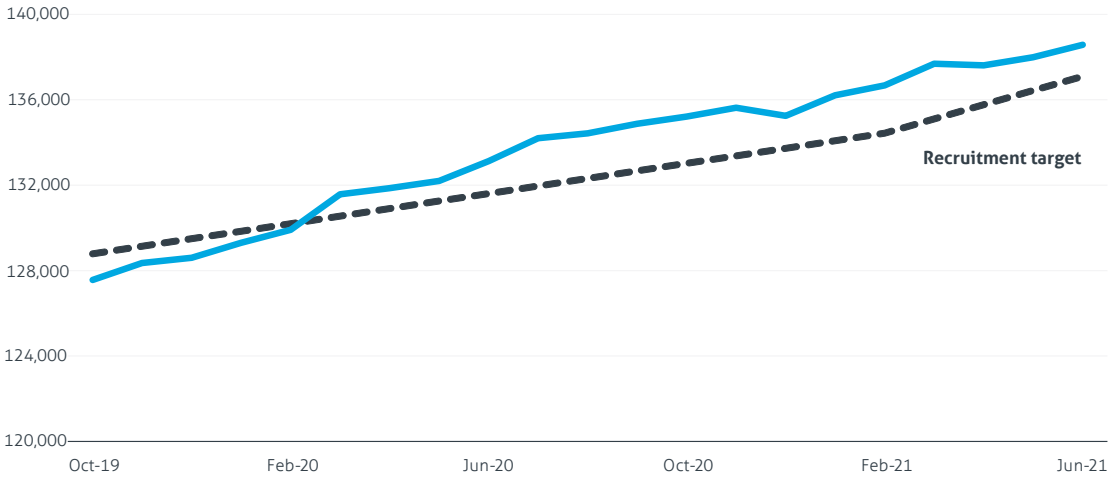
Police officers, like much of the population, have reported suffering from poor mental health and wellbeing this year. A survey conducted by the Police Federation found that 77% of respondents reported they had experienced feelings of stress, low mood, anxiety or other mental health difficulties over the last year. The majority of these respondents said psychological difficulties had been caused, or made worse, by work.[40]

Officers have been exposed to incidents that both place them at risk and cause considerable distress. Almost a third (32%) of those surveyed indicated that a member of the public, believed to be infected with Covid, had threatened to breathe or cough on them, and 24% reported a member of the public had actually attempted to do so.[41] Officers also reported that specific events related to coronavirus had been particularly disturbing, such as experiences of body recovery, family liaison work with those who had lost loved ones to the pandemic, and responding to an increased number of people with suicidal intentions, due to the wider mental health impact of the pandemic.[42]

Just over a quarter (27%) of officers said that the amount of overtime they work had increased during the pandemic compared to before, with officers working a median of 2.3 hours' overtime per week.[43] Staffing levels have also been met less frequently during the pandemic than before the crisis began, meaning there are fewer officers on shift. Senior police officers raised concerns about workforce fatigue during the second half of 2020, as police struggled to manage business as usual and Covid-specific duties – however this may be less of a problem once the pandemic ends.[44]

Despite increased levels of stress, retention and recruitment have both improved this year. At the end of March 2021, there were 135,501 police officers, compared to 129,110 in 2019/20. Fewer police officers left in 2020/21 (6,018) compared to in 2019/20 (7,141). A survey undertaken by Durham University and Oscar Kilo, the police wellbeing service, in November 2020, indicates that intention to quit has fallen a little since 2019. In 2020, it scored 3.28, on a scale of 1 to 7, compared to 3.47 in 2019.[45] The Police Federation's pay and morale survey also shows respondents were less likely to say they were seeking alternative employment in 2020 than in 2019, at 4% compared to 6%. Just 10% said they intended to leave the police service in the next two years or as soon as possible, compared to 16% in 2015.[46]

Figure 7.4 **Monthly increase in police officers since the uplift programme began (headcount)**



Source: Institute for Government analysis of Home Office, 'Police officer uplift', Table U1, October 2019–June 2021.

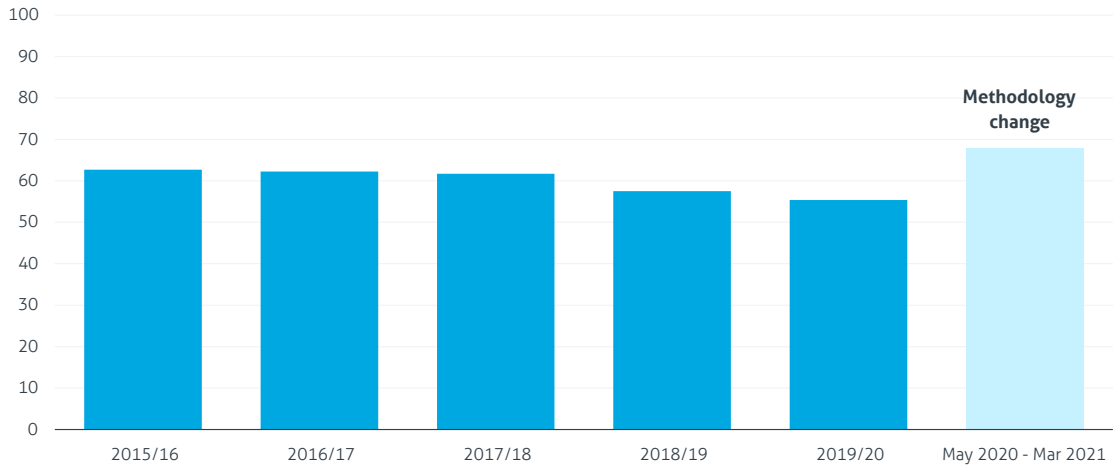
A large number of people joined the police force this year. The number of joiners fell slightly in 2020/21 to 12,127, compared to 12,883 in 2019/20, but this was still substantially higher than the number of joiners in 2018/19 (9,427). Part of this is due to the government's pre-Covid drive (which began in late 2019) to recruit an additional 20,000 police officers in England and Wales by 2023. Police forces in England and Wales received nearly 101,000 applications between October 2019 and August 2020 for the police uplift programme,[47] and as of 30 June 2021, 9,814 new officers have been recruited under the scheme, meaning the government is on track to hit its target of 20,000 extra police officers.[48] However, the new officers recruited this year lack the ethnic diversity pledged by the Home Office. By the end of June 2021, just 1.5% of all new officers recruited since April 2020 are Black,* a proportion approximately half the size of the Black population in England and Wales, while 11.3% describe themselves as 'Black, Asian, Mixed or Other'.[49] This means the proportion of Black officers remains at 1.3% of the total force,[50] up from 1% in 2007.[51]

In the long term, the pandemic may reduce police retention due to the pressures officers have faced over the past year. The Police Foundation and Crest Advisory, a criminal justice consultancy, are worried that "we have not yet seen the full extent of the impact that the last nine months has had on the police workforce".[52] Chief inspectors also reported higher average levels of intentions to quit in 2020 than in 2019.[53] A failure to retain experienced staff would be particularly problematic, given that 20,000 new recruits would not make up for the loss of experienced officers.[54] To avoid losing experienced officers, the government should focus on retention strategies to mitigate the effects of the pandemic. Police forces may need to introduce measures to help staff cope with longer-term effects of Covid as part of this, such as extra annual leave next year, or more support for officer mental health (which the introduction of the police covenant should help with).[55]

* This figure also includes officers recruited by means other than the uplift programme, such as through precept funding.

Public satisfaction with the police has fallen since 2016, but improved during the pandemic

Figure 7.5 **Percentage of people saying local police are doing a good/excellent job**



Source: Institute for Government analysis of Office for National Statistics, 'Crime in England and Wales: Annual supplementary tables', Table 2, 2015/16–2019/20; and Office for National Statistics, 'Crime in England and Wales: coronavirus (COVID-19) and crime tables', Table 4, 2020/21.*

Despite the rising number of police officers, public satisfaction with the police has been falling since 2016. In the year ending March 2020, just 55% of all adults surveyed for the CSEW said the local police were doing a good/excellent job, compared to 63% in 2016. However, this varies among different groups. For those who describe themselves as Black, satisfaction with the police has fallen at a faster rate, from 66% in 2016 to 53% in 2020. This means satisfaction with the police among the Black population went from slightly above average in 2016 to below average by 2020.[56]

This change may be due to increased racial disparity in the use of police powers. In 2019, the government gave police greater powers to use stop and search, reversing some earlier changes brought in after the 2011 riots. The *After the Riots* report[57] had recommended that the use of stop and search be cut and forces work to increase satisfaction levels among Black communities. The number of stops did fall after the publication of the report, and public trust in the police among Black communities rose. However, figures from Scotland Yard showed that in London in particular, the use of stop and searches conducted without reasonable suspicion increased over 400% between 2017/18 and 2018/19, and blanket searches are more racially disproportionate than targeted ones.[58] In 2019, Black people were 3.5 times more likely to be arrested, and 9.5 times more likely to be stopped and searched, than White people.[59]

* Supplementary tables were not published as part of the CSEW in 2020/21, 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 2021 figure represents the average of responses from each quarter.

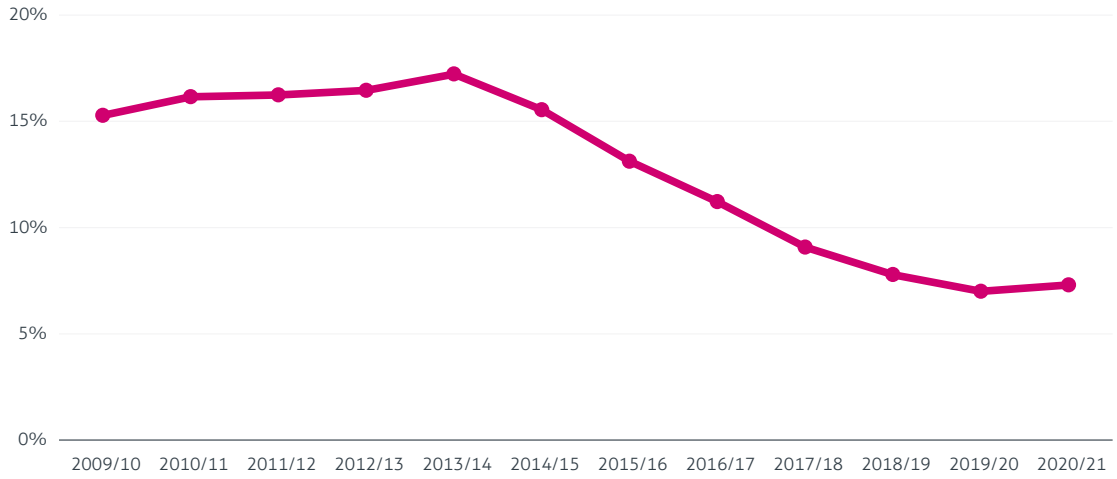
The CSEW did not ask the same question on public satisfaction with the police in 2020/21 – but a different set of coronavirus-related questions on local police indicates that public satisfaction may have improved. In May to June 2020, 70% of adults surveyed said the police were doing a good or excellent job. This fell slightly to 66% between October and December 2020 – although this was still higher than the 55% of respondents saying the police were doing a good/excellent job in 2019/20. Higher satisfaction with the police may be partly due to lower crime during the pandemic[60] – although 91% also said they were 'very satisfied' or 'fairly satisfied' with how police were responding to the Covid outbreak during the first lockdown.[61]

Despite overall improvements, some members of the public surveyed by Crest raised concerns about the police's actions during the pandemic. In particular, several respondents from Black and other ethnic minority groups indicated a 'heightened sensitivity' to police in relation to the new powers and the survey suggests that the police response to the pandemic may have reinforced some "pre-existing opinions on bias and uneven targeting by policing".[62] This is because Black and ethnic minority groups have been disproportionately targeted by coronavirus fines: analysis by Liberty Investigates and *The Guardian* found that between 27 March and 11 May 2020, Black and ethnic minority people were 54% more likely to be fined than White people.[63] Other events over the past year may also have affected public confidence in the police among certain groups. The Black Lives Matter protests raised questions about discriminatory policing practices and institutional racism in the police force.

The murder of Sarah Everard on 3 March 2021 when walking home through Brixton, south London, and subsequent protests may also have contributed to concern about the way in which the justice system treats women. A poll conducted by YouGov showed that the percentage of people who believe the police do not treat sexual assault seriously enough rose from 54% on 5 October 2020 to 68% on 22 March 2021.[64] However, this has not impacted women's confidence in the police: a poll conducted on 16/17 March showed that the same proportion of women (73%) agreed the police were doing a generally good job as on 1 March 2021.[65]

The proportion of crimes charged rose this year, after falling since 2014/15

Figure 7.6 **Proportion of crimes recorded by the police resulting in charges**



Source: Institute for Government analysis of Home Office, 'Crime outcomes in England and Wales', Table 2.2, 2009/10–2020/21.

The proportion of recorded crimes charged has consistently fallen since 2014/15, hitting a low of 7% in 2019/20. This is likely to be the result of falling officer numbers, rather than rising crime, because there has been a fall not only in the proportion of crimes charged but also in the number of crimes charged: from 603,989 in 2013/14 to 415,003 in 2019/20.

During the pandemic, the charging rate rose slightly, to 7.3%, reflecting both rising police officer numbers and falling crime. When crime rates fell, several forces' investigators were able to clear outstanding investigations, reduce backlogs and improve the quality of investigations, as there were fewer new cases – although this did not happen everywhere. The police inspectorate (Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services; HMICFRS) noted that some forces increased the number of crimes they decided not to investigate.[66]

Despite the rise in charging rates, the median number of days taken to charge an offence continued to rise this year, from 10 days in 2014/15 when data was first made available, to 33 days in 2019/20 and 43 days in 2020/21.[67] This increase partly reflects long-standing changes – the increase in complex and online crimes, which involve more evidence and take longer to investigate – and the specific impacts of the pandemic. The police inspectorate found that investigations took longer during the pandemic because fewer staff could safely be in workplaces to examine forensic and digital evidence, and obtaining witness statements and conducting suspect interviews – both of which are important in complex cases – was challenging when people were less willing to meet face-to-face with police.[68]

How much money would be required to maintain pre-pandemic standards?

Demands on the police are likely to rise in line with the size of the population in England and Wales, although incidents of certain crimes such as fraud and rape may increase at a faster rate, due to social trends and policing priorities. Unlike in other services, though, there is no evidence of a backlog that police must address, as the proportion of crimes charged has risen during the pandemic.

Predicting the call on policing services is difficult, given the variety of responsibilities police have and the lack of data on how much police resource these roles take up. Investigating and responding to crime costs the police the most, but crime data is affected by changes in reporting behaviour and classification, making it an imperfect indicator of how many offences are being committed and how crime rates have changed. The pandemic has introduced extra uncertainty, as evidence on the link between economic trends and crime is contested,[69,70] and the future economic outlook is highly uncertain.

In light of these complexities, we project how much money the police would have to spend if demands on policing simply increased in line with the size of the population. If this happened, police spending would have to rise by 2.3% between 2019/20 and 2024/25 to maintain service provision at 2019/20 levels.

This is likely to be an underestimate, however. Certain crimes – notably rape and fraud – are likely to rise at a faster rate than population growth. The government's recently published End-to-End Rape Review explicitly aims to increase the number of rape cases referred by police to the courts and to introduce performance scorecards to hold each part of the criminal justice system to account,[71] which will probably increase the number of rape cases the police investigate. Likewise, the government has made tackling cybercrime – which has increased rapidly since 2011/12 – a priority,[72] and the police will undoubtedly put more resources into tackling these offences over the next few years. If incidents of rape and fraud increase at twice the rate of population growth, the government will need to spend 3% more on policing, in real terms, in 2024/25 than it did in 2019/20 to maintain service provision.

How much would it cost to address the legacy of coronavirus in the police?

Both the above projections do not capture all uncertainties that could influence resource pressures on the police. If the government wanted forces to improve performance, for example by hiring and training specialist investigators to address fraud, it would need to spend more. If it chooses to increase staff pay above economy-wide inflation (likely to be high as a result of the pandemic) – which it may have to do as the current pay freeze is contentious – to help retain experienced officers, it would need to spend more too. If the police have to respond to more non-crime demands such as mental health incidents, another factor exacerbated during the crisis, spending may also increase.

8. Criminal courts

The criminal courts have been one of the public services worst affected by the coronavirus crisis. During the pandemic many cases have been heard remotely, and while this worked well in some instances it has had consequences for the quality of justice yet to be evaluated by the government. But the total number of cases processed has still been much lower as jury trials can happen only in person.

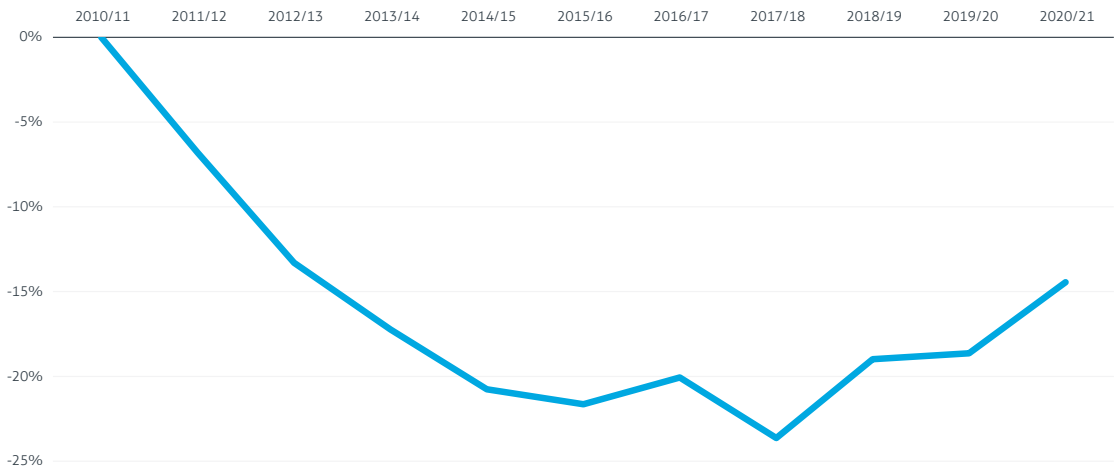
This has led to record backlogs that threaten the ability of the system to dispense justice. The focus over the coming years will be reducing the backlog, although the pace of the reduction will be limited by the number of judges and lawyers available and a probable increase in demand as additional police officers – a manifesto pledge – leads to more arrests and charges.

This chapter discusses criminal courts in England and Wales. Her Majesty's Courts and Tribunal Service (HMCTS), an executive agency within the Ministry of Justice, runs criminal courts in addition to family courts, civil courts and tribunals.

Spending increased to support courts during coronavirus

Total HMCTS spending was £2.0bn in 2019/20, 19% lower in real terms than it was in 2010/11. It increased slightly in response to the pandemic, but remained far below 2010/11 levels.

Figure 8.1 **HMCTS spending, real-terms percentage change since 2010/11**



Source: Institute for Government calculations using successive HMCTS annual reports. Figures deflated using the GDP deflator, where the deflator has been smoothed between 2019/20 and 2022/23 to account for the effects of the pandemic on its measurement.

HMCTS spent additional money in 2020/21 to adapt the court estate for Covid operations. This included renting 'Nightingale courts' (buildings used as temporary courtrooms) to expand capacity, new technology to enable remote hearings on a much greater scale, additional resources to keep courts clean and Covid-secure and some additional staffing.[1] In total, HMCTS was provided with an additional £175m in 2020/21 to cover these costs, 8% of its total budget.

Less crime during the pandemic meant the courts received fewer cases

Demand for the criminal courts is determined by activity 'upstream' in the criminal justice system – the activity of police and other bodies that can bring enforcement action against people suspected of minor offences, including motoring offences, fare evasion and failure to pay a TV licence. These bodies work with the Crown Prosecution Service (CPS) to decide which cases to bring to court. Cases received in the criminal courts have fallen since 2012 – and especially in the past few years – largely due to greater pressures on the police given their limited resources.[2] Figure 2 shows case receipts in the magistrates' courts, the 'gateway' to the criminal courts: all cases are first processed in the magistrates' and most stay there, with only the most serious transferred to the crown court.*

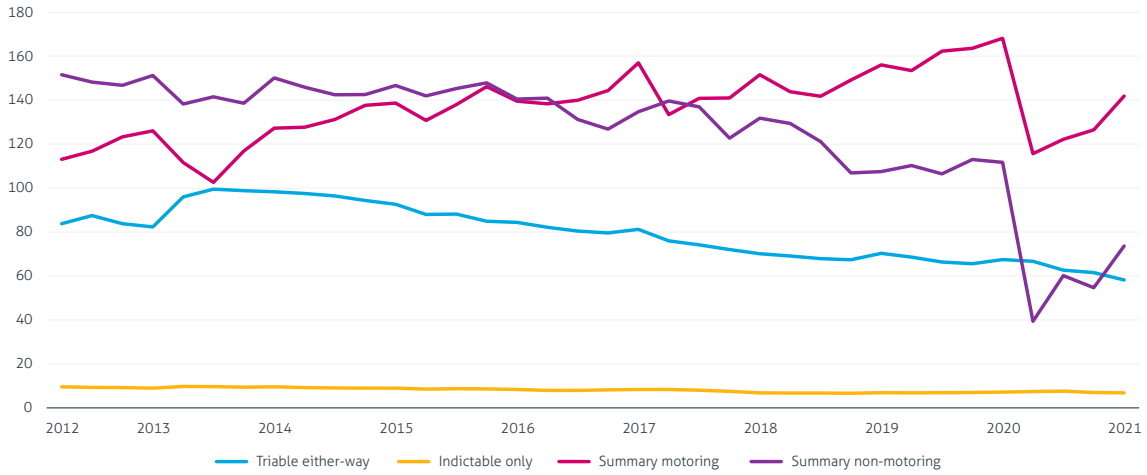
As Figure 2 shows, the number of cases entering the magistrates' court fell sharply in the second quarter of 2020, but this was mostly driven by less serious ('summary') cases, which account for most cases received. Despite lower levels of crime during the first lockdown and police time being taken up with policing Covid restrictions, the pipeline of serious cases from the police and CPS was much less affected and police charged a broadly similar number of cases to 2019 in 2020.[3] Motoring cases have since returned to pre-pandemic levels as more people have returned to the roads, but non-motoring summary cases (such as rail fare evasion) have not. This is both because some activities have not returned to normal (for example, train occupancy remains below capacity so fare evasion is lower) and because some enforcement authorities are taking a less aggressive approach. Many of these offences have a statute of limitations of six months,[4] so it is unlikely that lower case levels now will mean a spike in the future.

Across 2020/21 as a whole, there were 28% fewer cases received than in 2019/20. However, this overstates the fall in 'demand' on the criminal courts. Cases that are referred to the crown court are much more time-intensive and costly to process, whereas summary cases can be dealt with quickly and at low cost. Since 2015, most summary cases have been processed via the single justice procedure (SJP), whereby the defendant does not need to appear in court and cases are decided by a magistrate sitting alone with a legal adviser. In 2020/21, more than 50% of all cases processed in the magistrates' (and over 70% of summary cases) were administered this way.

* Magistrates' court cases are predominantly 'summary offences' – such as motoring offences – which do not result in prison sentences. Magistrates can sentence defendants to up to six months in prison.

Nonetheless, it is notable that the number of serious cases (triable either way and indictable only in Figure 2) has continued to fall, in keeping with a long-running trend. Between Q1 2014 and Q4 2019, the number of serious cases received in the magistrates' courts fell by one third, a rate of 7% per year. In the last year, lockdown has limited what people can do and led to a fall in some crimes. However, this trend is unlikely to continue indefinitely. The number of crimes that reach the court is not simply determined by the number of crimes *committed*, but by the number of police officers that can investigate them. That number has already begun to rise and should soon lead to a growth in case receipts.[5] This will put more pressure on the courts system.

Figure 8.2 **Magistrates' court case receipts by type (thousands)**

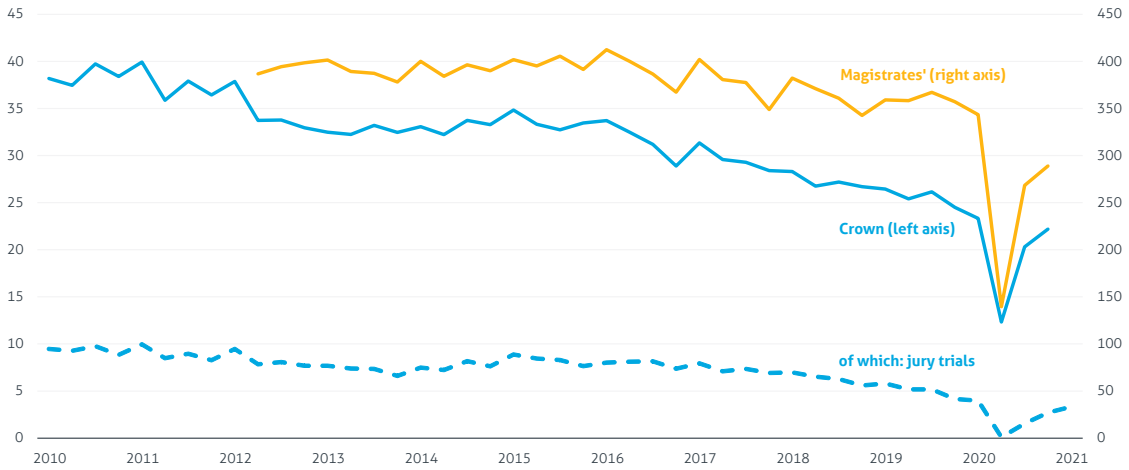


Source: Institute for Government analysis of HMCTS, 'Criminal court statistics January-March 2021', June 2021, Table M1.

Despite the expansion of remote hearings, the criminal courts have processed fewer cases, and there have been many fewer jury trials

While demand for the criminal courts fell, the courts' capacity to process cases fell by more. Lockdowns and enforced social distancing made the courts' usual ways of working impracticable. Initially, in March and April 2020, many courts were closed. Despite many years of digital investment in the courts (discussed below), the capacity for remote hearings had not been established, and so the total number of cases processed fell dramatically. Jury trials were suspended entirely after the government and judiciary decided that they should not be held remotely and it was not possible to fit all necessary attendees in a courtroom with adequate social distancing.[6] In the whole of the second quarter of 2020, only 99 jury trials were completed, compared with an average of 5,000 per quarter in 2019.

Figure 8.3 **Cases processed in the magistrates' court (right axis) and crown court (left axis) (thousands)**



Source: Institute for Government calculations using HMCTS, 'Criminal court statistics January-March 2021', June 2021, Tables M1, C1 and C2.

Since June 2020, the number of cases processed has recovered, although still not to normal pre-pandemic levels. In the magistrates' court, the number of cases processed has matched the number of case receipts (which have been below pre-crisis levels). This reflects a similar number of serious crime cases processed as before the crisis, but fewer summary offences as fewer of those have been prosecuted.

In the crown court, cases that do not require a jury trial are being processed at the same rate as before the pandemic and have been doing so since December 2020, which is an impressive achievement. This accounts for most cases – around 80% before Covid – and includes sentencing hearings, appeals of magistrates' decisions and any case for trial in which the defendant pleads guilty (and so a jury is not required). However, these cases are also much quicker to process. As there is no need for lengthy hearings and evidence, in normal times these cases account for less than 20% of total hearing time.[7]

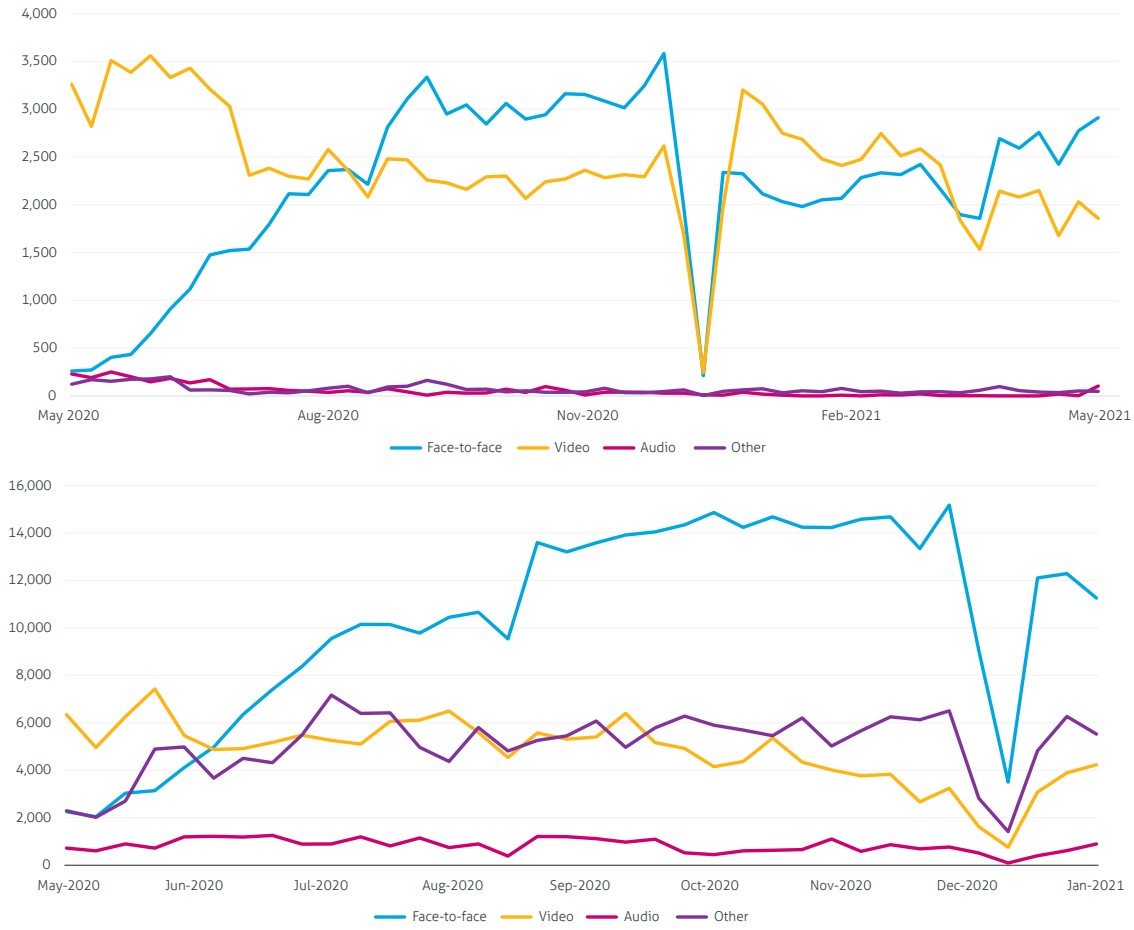
The only way that the courts have managed to process as many cases as they have is by making much greater use of remote hearings. In the magistrates' courts, SJP already was effectively a remote procedure for summary cases because it requires only one magistrate and legal adviser sitting alone (with no defendant present). However, before the pandemic almost all other hearings were in person. Similarly, crown court hearings have historically been heard almost exclusively in person.

However, that changed dramatically once the pandemic began. HMCTS rolled out a cloud video platform to enable remote hearings in April 2020.[8] In late May, almost 90% of crown court hearings and 60% of magistrates' hearings were happening remotely (see Figure 8.4), although in total the number of hearings held were only 77% and 84% of pre-pandemic levels respectively.* Almost all of these were via video. Hearings conducted face-to-face increased from May onwards as courtrooms

* A lower proportion of hearings in the magistrates' courts were by video because SJP cases are included in the total and could be processed as usual.

were adjusted and reopened, but remote hearings continued to make up a substantial share of the caseload. Throughout, jury trials only ever happened face-to-face, but most other types of hearing could be conducted remotely.[9]

Figure 8.4 **Hearings by mode in the crown court (top) and magistrates' courts (bottom)**



Source: Institute for Government calculations using HMCTS, 'Weekly use of remote hearing technologies in HMCTS', May 2021, www.gov.uk/government/collections/weekly-use-of-remote-hearing-technologies-in-hmcts. 'Other' = hearings under SJP.

HMCTS has increased its capacity to hold jury trials through the use of 'Nightingale courts'. Nightingale courts have opened across England and Wales and have mostly taken on non-jury trial cases to free up space in the main court estate for jury trials (which has appropriate cells for defendants on remand). During the pandemic, the crown courts have sometimes had to use up to three courtrooms to hold a jury trial to maintain social distancing, especially for cases with multiple defendants or with high public interest.[10] The government has also introduced extended operating hours so courts open for longer,[11] but the evidence on whether these actually increase the number of cases processed is unclear and this reform is very unpopular with barristers.

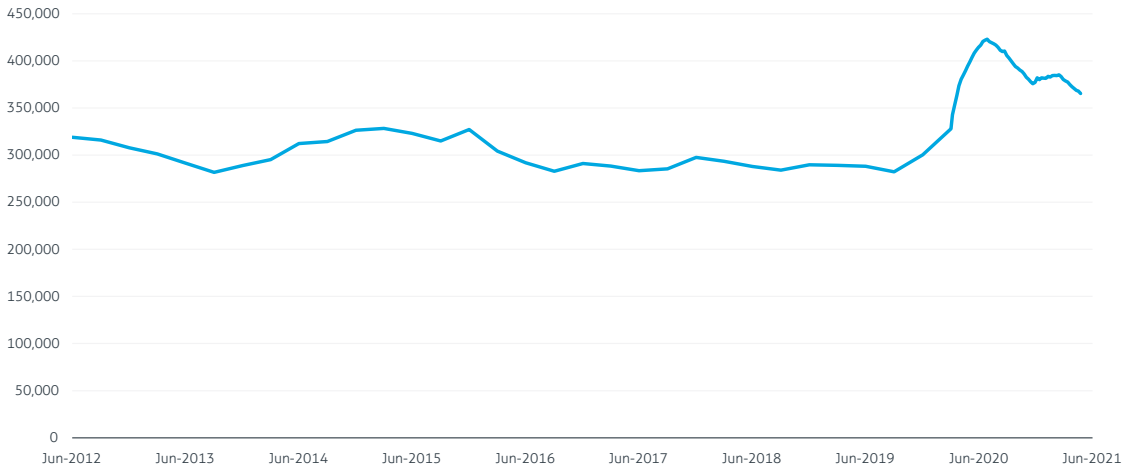
Despite the additional capacity, the number of jury trials processed remains below pre-pandemic levels. Even in the first quarter of 2021, a year on from the first national lockdown, the number of jury trials completed was only 60% of 2019 levels. This

is lower than the number of trials HMCTS hoped to process when it published its recovery plan in September 2020. That plan aimed to process 333 jury trials per week from November 2020.[12] In practice, it has averaged only 270 per week between November 2020 and May 2021.[13] Interviewees suggested that the HMCTS plans had been overly ambitious about how many courtrooms it would be able to make operational and also highlighted that a focus on more serious jury trials meant they took longer than anticipated.

Restrictions on court activity mean record-high backlogs in the crown court

Despite the expansion of remote hearings, overall activity has not kept pace with caseloads, especially in the crown court. In the magistrates' court, early in the pandemic the number of cases received outpaced the number processed. But as capacity for both remote and face-to-face hearings increased, the size of the backlog has fallen. At the end of May 2021, it remained 11% above pre-pandemic levels, but has continued to fall consistently and is likely to continue to do so as the impact of the pandemic on court capacity recedes.

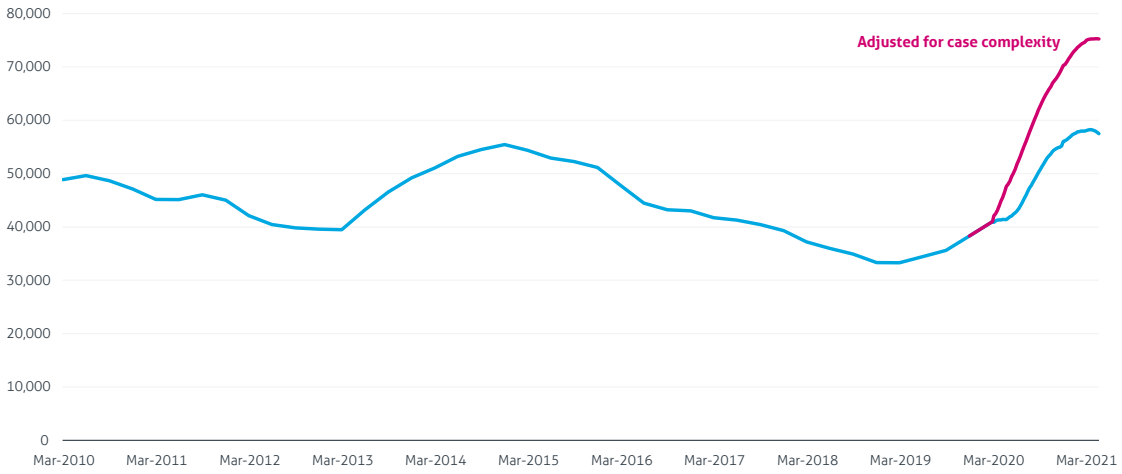
Figure 8.5 **Magistrates' court backlog**



Source: Institute for Government calculations using HMCTS, 'Criminal court statistics January-March 2021', June 2021, Table M1.

The picture in the crown court is much worse. Cases received via magistrates have outstripped those processed throughout the pandemic. At the end of May, the backlog was 50% higher than it was before the pandemic and – at 58,000 cases – the highest since at least 2000, when the data series starts. The true picture is much worse than this. As noted above, jury trials account for a minority of total cases but most of the total hearing time for crown courts – and have been disproportionately affected by the pandemic. Adjusting the new backlog to account for the fact that it includes a higher share of jury trials, we estimate that by the end of May 2021 the backlog was equivalent to 75,000 cases, almost double the pre-pandemic backlog and by far the largest on record.

Figure 8.6 **Crown court backlog**



Source: Institute for Government calculations using HMCTS, 'Criminal court statistics January-March 2021', June 2021, Table C1 and HMCTS, 'Weekly management information', June 2021.

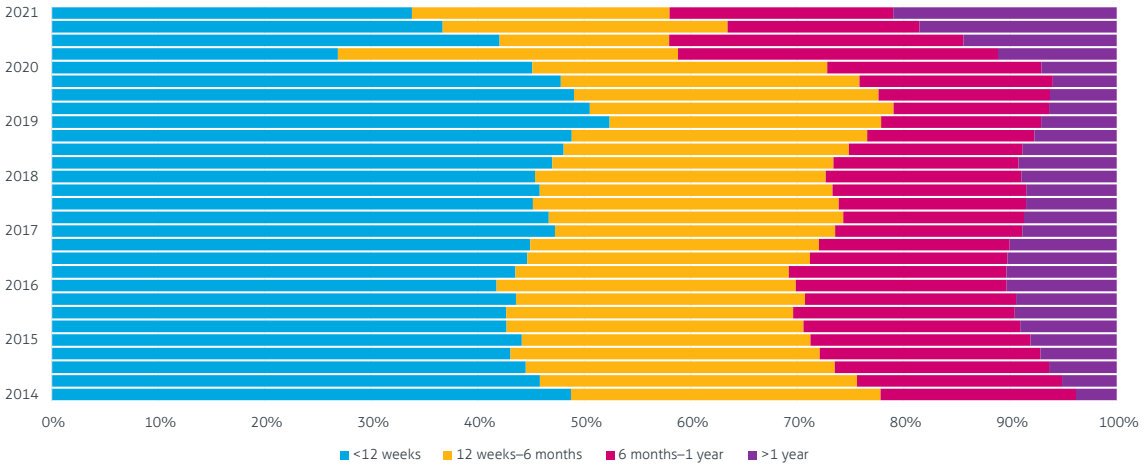
A higher backlog means much longer waiting times

The consequence of higher backlogs is that cases take longer to be processed. This means that defendants, victims and witnesses will all have longer to wait for their cases to conclude and for justice to be served.

Waiting times in the magistrates' court have increased. The average time between a case reaching the magistrates' and being processed has more than doubled – from 2.5 weeks to six between Q4 2019 and Q1 2021[14] (this is likely to fall over the next few quarters).

The problems with waiting times are most severe in the crown court, where the most serious cases are heard. Among cases that were still waiting to be heard at the end of March 2021, over 40% had been waiting for over six months already. This contrasts with only 25% in the fourth quarter of 2019. Among trial cases that were completed in the first quarter of 2021, the average total waiting time was 21.1 weeks, the highest on record. Among cases where a jury trial was necessary, the average waiting time was almost 40 weeks.[15] The large backlog means that these figures are likely to get worse before they get better.

Figure 8.7 **Waiting times for cases in the crown court backlog**



Source: Institute for Government calculations using HMCTS, 'Criminal court statistics January-March 2021', June 2021, Table O2.

Processing and hearing cases in a timely manner is not just a matter of court user satisfaction. Serving justice in a timely manner is vital to the effective operation of the system. Higher waiting times could affect the quality of justice dispensed in two ways – we have heard anecdotal evidence of both during the pandemic.

First, defendants deemed dangerous are kept in prison on remand while awaiting their trial. If the waiting time is too long, there is an incentive to plead guilty to serve a shorter prison sentence, rather than wait a long time for a trial and risk being found guilty and having to serve more time.[16] Despite the overall prison population falling during the pandemic, the number of prisoners on remand has risen.[17] While the courts try to prioritise cases for those on remand, the average waiting time for these has still increased substantially and the length of time that a defendant can legally be held on remand has been extended temporarily from 182 days to 238 days.[18,19]

Second, longer waiting times are more likely to result in cases collapsing. This could be because victims no longer want to provide evidence or witnesses' recall of events may not be good enough. This provides an incentive for guilty defendants (especially if they are on bail rather than remand) to plead not guilty and hope the prosecution collapses before the trial. In 2020, a quarter of cases collapsed because the victim no longer supported the action, the highest level on record.[20] If this trend were to become more widespread, it would put the system under even more pressure because it would mean more jury trials and fewer guilty pleas, which would require more court time.

Lawyers and others are concerned that remote hearings do not deliver high-quality justice

Even the cases that have been heard this year have largely been conducted remotely. This has been necessary to prevent an even larger backlog, but doubts remain over the quality of justice dispensed. While some have suggested that greater use of remote hearings could be a way to reduce the backlog, the experience during the pandemic presents at best a mixed picture and more evaluation is required.

The use of remote hearings in the courts was not wholly unprecedented or unplanned. Since 2016, HMCTS has been implementing a court reform programme. This included plans for a common platform to make the courts paperless and to invest in technology to allow for greater use of remote hearings.[21] But coronavirus led to a much more rapid and extensive expansion of remote hearings than was ever envisioned by HMCTS. Some early tests had taken place, in tribunals, before 2020,[22] but there were no imminent plans to extend this to criminal courts. In large part, this was due to opposition from judges, who retain control over scheduling and listing how hearings are conducted in their courtrooms. The nature of the Covid crisis meant that they were much more willing to use remote hearings – not least as there was no alternative.

While rapid evaluations of the impact of remote hearings took place in the civil[23] and family[24] courts in 2020, no such evaluation has yet been carried out for criminal cases. Practitioners have reported that video works well for short procedural hearings that require no substantive engagement on the part of witnesses, defendants or barristers – but that in substantive hearings video interactions are not as effective[25] and that it can be difficult for vulnerable defendants in particular to engage with the process.[26] Of barristers surveyed by the Bar Council, 82% reported some problem with the court system, and by far the most common complaint was of technical issues with the video platform.[27] Other countries have also increased the use of remote hearings, and surveys in those countries have found similar problems.[28]

Despite widespread use of remote hearings during the pandemic, more evidence is needed before the courts should hold substantive hearings remotely once the pandemic has passed. Beyond the concerns noted above about the experience of participants, HMCTS needs to study whether and to what extent hearings held remotely lead to different outcomes than face-to-face hearings. Many of the temporary powers that allowed for widespread remote hearings in the Coronavirus Act 2020 would be made permanent in the Police, Crime and Sentencing Bill.* The current version of that bill also proposes that parliament grant ministers the power to allow jury trials to be held remotely, although they currently have no plan to do so.[29]

Ultimately, the hearing mode in different courts will be at the discretion of judges, but HMCTS should make collecting evidence on the impact of different hearing modes a priority to ensure judges' decisions are as informed as possible.

* At the time of publication in the Lords.

Judge and lawyer capacity will constrain how many cases can be processed

As the impact of coronavirus recedes, the government's focus will be on increasing the number of cases that the criminal courts can process to reduce the backlog. Ordinarily, the capacity of the courts is determined by the number of sitting days – effectively, the amount of judicial time that the government is willing to fund in that year. But the government has announced that it will provide funding for unlimited sitting days,[30] which means that the number of judges will instead be the key constraint on how many cases can be processed.

Two types of judge hear most of the cases in the crown court. Circuit judges, who are salaried, account for most sittings, with most of the remainder heard by recorders – part-time judges that practise as barristers but hear a few cases each year. The sitting days of circuit judges remained relatively stable in the years leading up to the pandemic, while the cases heard by recorders fluctuated according to demand. For example, in 2019 circuit judges accounted for 76,000 sitting days and recorders 9,000, but in 2017 circuit judges accounted for 78,000 and recorders 24,000.[31]

The number of circuit judges remains similar to mid-2010s levels. It will therefore be difficult to expand the number of cases heard by this group unless more are hired. However, filling judicial appointments has proved difficult for several years.[32] In part, this is likely to be because most people take a pay cut when joining the judiciary. Judicial pensions are less generous now than they were a few years ago, and this is the main reason why the judiciary report they would not "recommend the role to a suitable candidate".[33] But the pipeline of suitably qualified people is also dwindling. In 2019/20 there were 22% fewer QCs specialising in criminal law – the likely pool of applicants – than in 2015/16.[34] This is because specialist criminal barristers are increasingly diversifying into other areas of law as incomes in crime work – and especially publicly funded crime work – are not competitive. This also means that there could be a shortage of barristers to prosecute and defend cases.

Retaining existing judges may also prove difficult in the future. In the 2020 Judicial Attitude Survey, one third of judges who were not up for retirement reported that they intended to retire in the next five years. This is not coronavirus related – the share was 36% in the 2016 survey – but points to continuing pressures. A further 15% are set to reach compulsory retirement (at 70) in the next five years,[35] although the government intends to increase the mandatory retirement age to 75.[36]

There will also be limits to how many cases recorders can hear, although they will be able to hear many more than they did in 2019/20 – close to the 25,000 heard in 2016. At present, a single recorder is expected to sit for only 30 sessions in a year.[37] As recorders tend to be practising barristers, the fall in senior criminal barristers has similarly reduced the pool of possible recorders. Given the potential shortage of barristers as activity in the courts increases, recorders will probably be needed to act as barristers in cases rather than sitting as judges. As a result, judicial capacity and the number of lawyers are likely to be the main constraining factors on criminal court activity.

How much would it cost the criminal courts to maintain pre-pandemic standards?

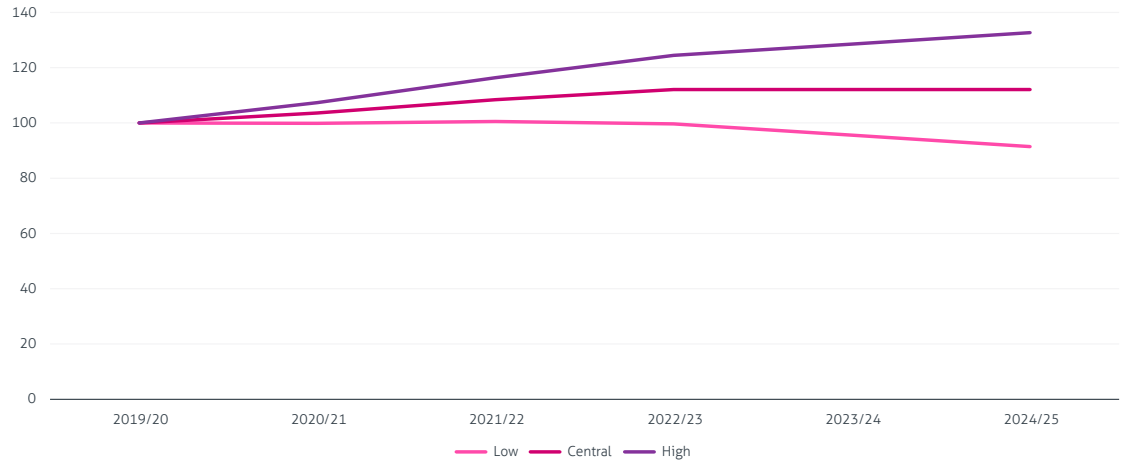
The priority for the courts in the coming years will be increasing court capacity sufficiently to eliminate pandemic-related backlogs. This will require more spending and – potentially – a need to focus on recruiting more judges. However, even without the impact of coronavirus the criminal courts would have been under strain. More police officers will mean growing demand over the next few years and will require additional spending if they are to keep up. The pace of the demand increase will depend on how many more suspects the government's extra 20,000 police officers can charge. These two challenges are linked: if demand increases more quickly, it will be more costly and time consuming to run the courts at a high enough capacity to eliminate backlogs.

Demand for the criminal courts depends on what happens 'upstream' in the criminal justice system – namely, the police. If the police charge more suspects, this means more cases to be heard in court. Over the last few years, the number of cases charged by the police has fallen – from more than 650,000 in 2011/12 to only 409,000 in 2019/20.[38] The number of police officers fell by 20,000 over this period, but charges per officer also fell due to a combination of factors, including the growing complexity of cases – in particular, using more and new types of evidence, such as digital media – and limited capacity at the Crown Prosecution Service (CPS) amid steep budget cuts.

Over the next few years we would expect this declining trend to reverse. The government is in the process of recruiting an additional 20,000 police officers, which will restore officer numbers to their early-2010s level, while in the 2019 spending review it also increased spending on the CPS to increase capacity. That said, it is also possible that the amount of evidence the police need to deal with will continue to increase, making the overall path of court demand uncertain.

Our scenarios project how demand would have changed in the absence of the pandemic. In our 'central scenario' we project that demand in 2024/25 will be 16% higher than it was in 2019/20. This is based on the number of charges per officer staying constant at 2019/20 levels as the number of police officers rises. If charges per officer continue to fall at the rate it has since 2014/15, our 'low demand' scenario (for example, if the amount of evidence continues to increase) demand would be 9% lower in 2024/25 than 2019/20. But if charges per officer recovers back towards 2014/15 levels, our 'high demand' scenario (for example, if additional funding for the CPS eases bottlenecks in the system) demand would be 32% higher in 2024/25.

Figure 8.8 **Projected change in demand in the criminal courts (2019/20=100)**



Source: Institute for Government assumptions and calculations.

In the central scenario, spending on the criminal courts would need to be £135m higher in real terms in 2024/25 than 2019/20. In the high demand scenario, it would need to increase by £334m. The former would be sufficient to return spending on the criminal courts to 2012/13 levels, and the latter to return spending to 2011/12 levels.

The government might be able to meet demand by spending less than this if it can provide its service more efficiently. However, there are not obvious sources of future efficiency savings. In principle, greater use of remote hearings might provide such an opportunity, and a rare positive legacy of the pandemic, but given that judges are expensive this may not actually work out cheaper if cases take longer to hear online (despite savings on the court estate). More fundamentally, and as mentioned above, there is no evidence that the quality of justice dispensed through remote hearings matches that of in-person hearings. There will be a small efficiency gain from processing more routine hearings online, but these account for a small minority of total court time.

How much would it cost to address the legacy of the pandemic in courts?

On top of increasing spending to meet growing demand, the criminal courts will also need to reduce backlogs to pre-Covid levels to return their performance to 2019/20 levels. As we showed above, there was a small reduction in the number of cases coming into the criminal courts, but the capacity to process cases fell by much more.

In the magistrates' courts, backlogs rose initially but have fallen since. They are now only 3% above pre-pandemic levels, and as such clearing the remaining Covid backlog would cost only £11m and should be deliverable within 2021/22 or – at worst – 2022/23. However, the backlogs in the crown court are much more problematic. When adjusted for the complexity of cases added (which will disproportionately require jury trials), the current backlog is now more than twice what it was before 2020. Finding enough hearing time to process these cases – and to return the backlog to pre-pandemic levels – would require the equivalent of 44% of 2019/20 crown court capacity and will cost £300m for the extra judicial time, staffing and court space.

Unlimited sitting days in the crown court means that the main constraint is judicial capacity. Such a large backlog could not, on top of meeting new demand, be alleviated in one year. If the criminal courts were to operate at the peak level of 2015/16 (115,000 sitting days) from September 2021, the backlog would be back to pre-pandemic levels in December 2023; in the low demand scenario, in December 2022. But in the high demand scenario, by 2023/24 even processing as many cases as the criminal courts did in 2015/16 would only be sufficient to meet new demand without making any indent into the backlog.

The government could accelerate these timetables for reducing the backlog by increasing judicial capacity. However, the problem of attracting judges makes this very expensive. It would also need to attract more barristers to work on crime, which might require additional legal aid spending to make crime work more competitive. Either way, it seems likely that the government will need to spend more on the courts in the coming years to return the quality of the service to pre-pandemic levels. This includes a longer-term spending commitment to meet growing demand and more money in the short term to reduce backlogs.

9. Prisons

Prisons have not operated as normal during the pandemic. Following warnings from Public Health England about the possibility of Covid spreading rapidly and leading to large numbers of deaths among prisoners, Her Majesty's Prison and Probation Service imposed severe restrictions across all prisons in March 2020. The measures were effective: as of the end of August 2021, there had been 155 Covid-related deaths in prison, a fraction of PHE's warning that fatalities could reach 2,700.

But this came at the expense of prisoner welfare – most prisoners have been locked in their cells for 23 hours a day for the past year, and denied purposeful rehabilitative activity such as employment and training. These factors will have had an as yet unrealised longer-term impact on their needs, and on officers' ability to safely supervise them.

The number of people held in prison dropped during the pandemic as lockdowns led to delays in court hearings, but will rise again as the courts recover from the pandemic and target the backlog. The government's promised 20,000 extra police officers will also lead to an influx of prisoners. Both will put greater pressure on already crowded prisons.

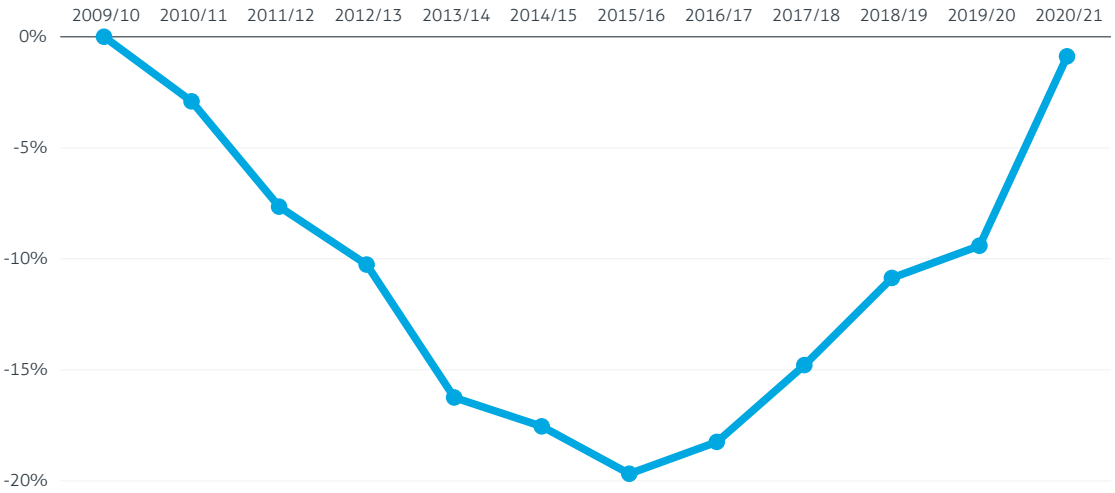
This chapter considers the 117 publicly and privately run prisons in England and Wales. Her Majesty's Prison and Probation Service (HMPPS), an executive agency within the Ministry of Justice, runs 104 of these, while Serco, G4S and Sodexo run the remaining 13.

Spending on prisons has been rising since 2015/16 and the pandemic led to further increases

Spending on prisons has been rising in real terms since Theresa May's government allocated £291m over three years to improve prison safety in 2016.[1] Between 2015/16 and 2018/19, spending rose by 11%. Immediately before the pandemic, though, increases had slowed: between 2018/19 and 2019/20, spending rose by just 1.6% in real terms. The pandemic is likely to have caused spending to increase rapidly again, although total figures for the 2020/21 financial year have not yet been published. In its submission to parliament for additional resources, the Ministry of Justice (MoJ) estimated that HMPPS would spend £4.65bn on prisons and probation in 2020/21, 4.8% more than planned for in the original budget set in March 2020.[2] This equates to a cash-terms increase of 11% on the £4.19bn spent in 2019/20.[3,*] If prison spending changes in line with total HMPPS spending, then spending on prisons in 2020/21 will be higher in real terms than in 2019/20.

* Supplementary estimates indicate HMPPS spent £213m more than budgeted for between March 2020 and February 2021. The National Audit Office estimates that this figure rose to £286m by September 2021.

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



Source: Institute for Government analysis of MoJ, 'Costs per prison place and prisoner by individual prison', 2009/10–2019/20 & HM Treasury, *Central Government Supply Estimates 2020–21: Supplementary Estimates*, 2021.

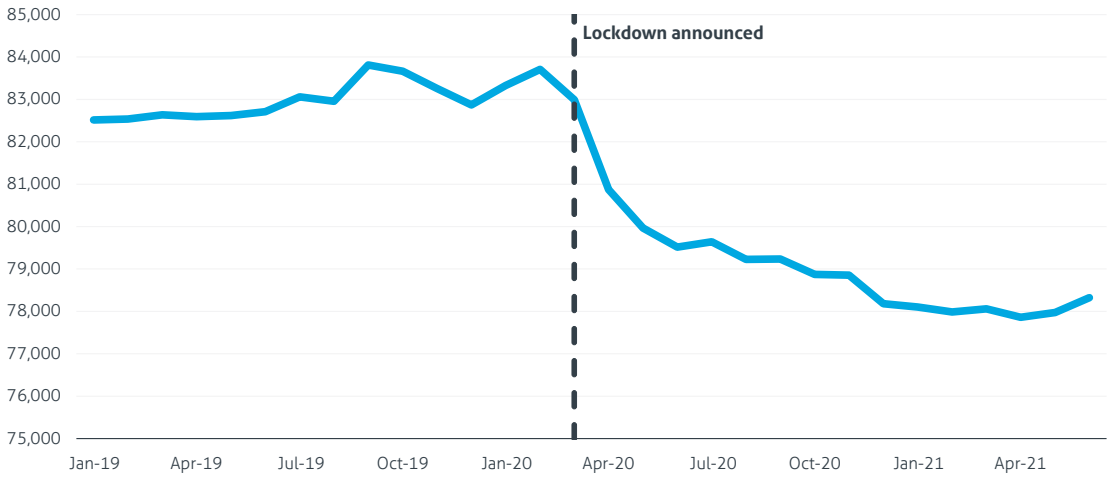
Most extra spending has been on capital (investment) projects such as installing telephones in prisoners' cells, in response to social distancing measures and the suspension of in-person visits throughout most of 2020.[4] In June 2020, the government announced £140m to install temporary prison cells, refurbish prisons and young offender institutions, and improve IT provision across the prison estate.[5,6] The MoJ has since installed 1,200 temporary 'pods' – single-occupancy cells designed to reduce the number of prisoners sharing cells and ensure social distancing and shielding were possible – and provided new phone handsets, in-cell telephones and extra mobile credit to prisoners.[7] The government allocated a further £43m for measures to reduce Covid transmission in prisons and courts in the November 2020 spending review.[8]

New technology like in-cell phones and video calling facilities has been positively received by staff and prisoners and may be retained after the pandemic, but it is not yet clear if these will be one-off costs or entail permanently higher spending in future years.

* We estimate 2020/21 prisons spending by assuming that spending in prisons rises in line with increases in the HMPPS programme budget (Resource DEL, minus administration costs) reported in the 2019/20 annual accounts and the HMT 2020/21 supplementary estimates. See: Ministry of Justice, *Ministry of Justice Annual Report and Accounts 2019-20* (HC 711), The Stationery Office, November 2020, p. 222, 226; HM Treasury, *Central Government Supply Estimates 2020-21: Supplementary Estimates* (HC 1227), The Stationery Office, February 2021, p. 138.

The number of prisoners fell 6% during the pandemic but is likely to rise again

Figure 9.2 **Monthly number of prisoners in England and Wales**



Source: Institute for Government analysis of MoJ, 'Offender management statistics quarterly', Table 1.1 Prison population, 31 January 2019 to 30 June 2021.

The prison population in England and Wales remained broadly unchanged between 2009 and 2019, with prisoner numbers sitting consistently above 80,000. Over the past year, however, that number has reduced as fewer people have been sent to prison from the courts. In March 2021, there were 78,058 people in prison, 6% fewer than in March 2020,[9] and the lowest number since 2005.[10]

This drop is largely the result of a reduction in the number of people entering prison. Fewer cases have been heard in the criminal courts due to social distancing, resulting in fewer people being sentenced. Between April and June 2020, just 12,608 people entered prison, compared to 18,370 in the same period in 2019.[11] At the start of the pandemic the government also brought in an early release scheme, for which approximately 4,000 low-risk prisoners were eligible. But far fewer prisoners were released than proposed as restrictions stopped the spread of the virus and ended the need to release prisoners:[12] between April and August 2020, less than a tenth of all eligible prisoners (262) were released under the scheme.[13]

The reduction in prisoner numbers means overcrowding, a long-standing problem in English and Welsh prisons, has also fallen to its lowest point in over a decade this year. In 2014/15, the year with the highest overcrowding in prisons since data publication began in 1998/99, just over a quarter (25.5%) of prisoners were held in crowded accommodation – defined as a cell in which the number of occupants exceeds intended capacity – but in 2020/21 this had fallen to 20.2%.[14] This is the lowest proportion since 2002 and is the result of both the reduced prison population and the addition of temporary pods to the prison estate. Overcrowding has contributed to poor living conditions and declining safety, but while this can be seen as a rare positive effect of the pandemic it is likely to be only short-term.[15]

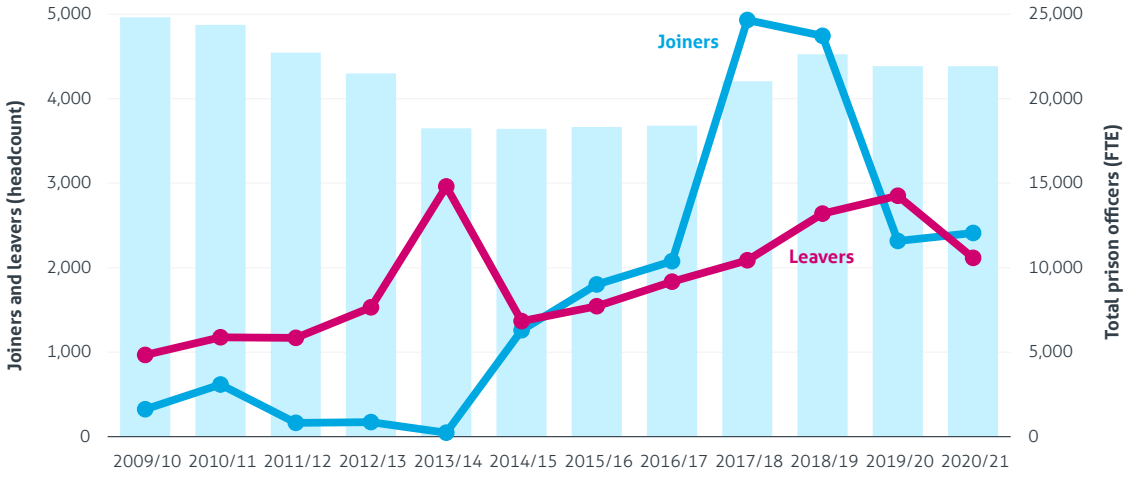
While the total number of prisoners has fallen, the number of people on remand (held in prison while awaiting trial) has increased, from 9,969 at the end of January 2020 to 12,727 at the end of June 2021 – a jump from 12% of the total prison population to 16.2%.[16] This has potential effects on the quality of justice dispensed,* and has also strained the mental health of those awaiting trial.[17] MoJ predicts that the remand population will continue to rise in the next three years due to the impact of additional police officers.[18]

The decline in the prison population will not last. MoJ predicts the prison population will reach 98,700 (its highest ever level) by September 2026.[19] Criminal courts will process more cases to reduce the backlog (present before the pandemic, and exacerbated by it), which will increase the flow of people entering prisons. And the government's proposal to recruit an additional 20,000 police officers, a key manifesto pledge, is almost certain to result in more criminals being charged, and sentenced, over the coming years.

The increase in the number of people entering prisons as the pandemic recedes will duly increase pressure on prisons. At the end of August 2021, the total 'useable operational capacity' – the number of prisoners the government thinks can be held safely and securely, if not at the standard desired – across all prisons in England and Wales was 80,641, just above the number of people currently in prison.[20] The government's current projections imply a need for many more places.

Staff retention increased during the pandemic but recruitment has fallen significantly since 2018/19

Figure 9.3 **Total number of Band 3–5 prison officers, joiners and leavers**



Source: Institute for Government analysis of HMPPS, 'Workforce statistics bulletin', Tables 3, 8a and 8c, 2009/10–2020/21.

Prison officers have experienced improvements in the conditions of their jobs from lockdown regimes. Reducing the number of prisoners allowed out at any one time has lowered the prisoner-to-staff ratio to manageable levels – falling from around 1:30

* For more on this see Chapter 8.

before the pandemic, to 1:16 this year – and as a result, officers have experienced fewer assaults.[21] The increasingly unsafe working environment has been a big problem for officers over the last decade, and a study conducted before the pandemic indicated that safety was a key factor influencing officers' decisions to leave the service.[22]

Both recruitment and retention improved during the pandemic compared to the year before. In 2020/21, fewer officers left the prison service (2,116) than the year before (2,852) – the first time this has happened since 2014/15. There were also slightly more new joiners in 2020/21 (2,410) compared to 2019/20 (2,317).[23]

Higher retention and recruitment is in line with the trend in most public services during the pandemic, and it is likely that the reduction in vacancies and job security in other sectors has contributed to this.[24] A similar trend was seen in the prison service after the 2008 financial crisis.[25]

The higher retention rate means officer numbers have remained constant this year but again this is unlikely to be sustained even in the short term. Officer numbers had started to fall again before the pandemic hit and there were 3% fewer prison officers at the end of March 2020 than March 2019.[26] This was due to both a rising number of leavers, and a decreasing number of joiners – the latter of which halved at the end of the May government's three-year recruitment drive. In the medium term the government will need to increase recruitment, in line with their plans to build more prison places, to reverse this trend.

However, retention is likely to remain a problem: the number of leavers had been rising steadily since 2014/15. Pay is an important factor. Before the pandemic, the Prison Service Pay Review Body noted that the prison service was struggling to retain staff at Band 3 – the entry-level grade for operational roles – as the salary is less competitive than other jobs in the same occupational group.[27] Many recent leavers have left early in their careers: in the year to March 2020, 60% had completed no more than two years of service, compared to 24% of leavers in the year to 2016.[28]

This may cause problems later on. If staff do not remain in the prison service and build up experience, the future mix of officers is likely to be less skilled than before, which will in turn reduce their ability to safely supervise prisoners.[29] The government did not fulfil the Pay Review Body's recommendation in 2020 that it raise Band 3 salaries by £3,000 – and has instead introduced a pay freeze for prison officers this year.[30] If job opportunities recover quickly in other sectors, uncompetitive prison pay could mean prisons struggle to retain staff in the near future.

The exceptional experience of the pandemic could further compound problems. There is burnout among staff, many of whom have had to work overtime to cover for self-isolating colleagues and been unable to take leave,[31] and 81% of prison officers surveyed by Royal Holloway University said their mental health had got worse during the pandemic.[32] This was largely linked to specific Covid factors – such as the poor standard of infection control measures in place in prisons, and fears that their employment was putting family at risk. It is not clear if this will have increased staff leaving intentions, but is unlikely to improve retention.

Prisons became safer, but lockdown regimes affected prisoners' wellbeing

There are many ways to measure prison performance in England and Wales but two critical ones are the safety of prisoners and provision of rehabilitation. Prison safety increased notably during the pandemic, but this came at the cost of the provision of rehabilitation, with many prisoner programmes severely curtailed – also having a negative effect on prisoners' mental health.

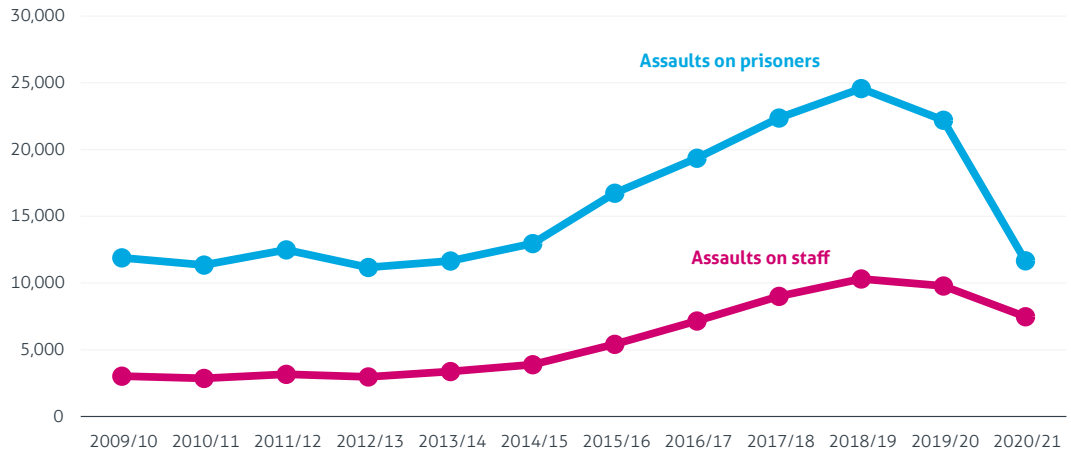
Prisoners spent at least 23 hours a day in their cells during the pandemic, with some being allowed as little as 30 minutes a day outside their cells to shower and/or exercise. Purposeful activity – including education, vocational training and employment – ceased for most prisoners at the start of lockdown. A few prisons and young offender institutions have reintroduced some form of education,[33] and in-cell work packs have been provided in many establishments, but the quality of these varied considerably.[34]

In a survey conducted by HM Inspectorate of Prisons (HMIP), less than half of prisoners who had received such packs said they were helpful, due partly to the limited feedback they received from teachers. Education packs are also less helpful for prisoners with low levels of literacy or special educational needs and/or disabilities. The chief inspectors of Ofsted and HMIP have noted that remote learning has had a detrimental impact on prisoners' learning outcomes – and the quality of education in prisons was already poor before the pandemic.[35]

Many fewer prisoners have also been eligible to leave on 'release on temporary licence', which can be used for employment, visiting family or to prepare them for resettlement. In the year to December 2020, there were just 184,465 incidences of such release, compared to 436,531 in 2019.[36]

Prisoner assaults on staff and other prisoners have fallen this year

Figure 9.4 **Prisoner assaults on staff and other prisoners**



Source: Institute for Government analysis of MoJ, 'Safety in custody statistics', Table 4, 2009/10–2020/21.

Violence in prisons rose dramatically after 2014/15 but fell even faster during the pandemic, when there were steep drops in the number of recorded prisoner assaults on both other prisoners and staff. Assaults on prisoners were 47.4% lower in 2020/21 than in 2019/20, and assaults on staff 23.6% lower over the same period. The number of prisoner-on-prisoner assaults is still higher than those on staff, but numbers are now almost 2% lower than in 2009/10. The number of serious assaults also fell considerably – from 3,681 in 2019/20 to 1,954 in 2020/21.[37] Poor behaviour fell during the pandemic too: there were 34.2% fewer incidents of protesting* in 2020/21 compared to in 2019/20.[38]

The number of assaults has fallen because prisoners have spent less time with other prisoners. This was most obvious during the lockdowns but even when restrictions were eased over the summer, inmates were allowed to socialise in groups of only 15–20 – and officers assigned to work with specific small groups rather than whole wings. The Prison Officers' Association (POA) attributes the decline in violence to these changes and there may be more permanent benefits for staff in restricting the size of prisoner groups.[39] This would mean prisoners spend longer locked in cells, due to staff numbers. The prison service has launched a review into what changes should be made to the way prisoners spend their days.[40]

The impact on prisoners may be less beneficial, however. Though there has been an overall drop in recorded assaults, headline figures hide wide variations across different prisons. HMIP reports indicate that several prisons, such as HMP Erlestoke,[41] HMP Coldingley and HMP Portland, have had no decline in violence.[42]

* Incidents of 'protesting behaviour' in prisons are split into four categories: barricades/prevention of access, where prisoners use a physical barrier to deny access to all or part of a prison; hostage incidents, where prisoners hold people against their will; concerted indiscipline, where two or more prisoners refuse to comply with rules; and incidents at height, which refers to any incident taking place above or below ground level and includes climbing over bars or on to the roof. We compare the total of all types of incidents here.

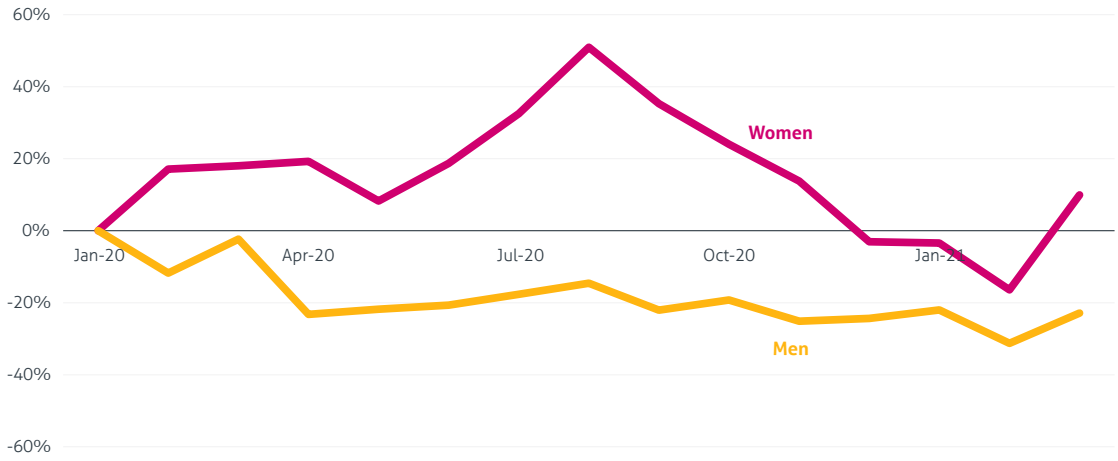
Assaults also have to be witnessed to be recorded – and prisoners told HMIP that incidents were taking place out of sight of staff (in shower areas and shared cells, for instance) so it is possible that some assaults have not been captured by the statistics this year.[43]

There was also a small rise in the number of assaults on staff and prisoners over the summer months of 2020, from the lows seen during the first lockdown – but these numbers remained far lower than those recorded before the pandemic.[44] Research from the Prison Reform Trust indicates that although prisoners were compliant when lockdown began, as they understood the reasons for the new regime, they became particularly frustrated during the summer that restrictions were eased in the outside world much more quickly than in prisons.[45,46] Without legitimate avenues to voice their frustration with restricted regimes, this may account for the brief rise in violence.

HMIP has warned that "there is a danger of learning the wrong lessons from the pandemic by assuming that the solution to prison violence is to isolate prisoners".[47] The causes of violence need to be addressed, while it should be acknowledged that permanently restrictive regimes stem prisoners' ability to participate in meaningful activity and pursue rehabilitation.

Self-harm levels have dropped during the pandemic – but headline figures hide a rise in self-harm among female prisoners

Figure 9.5 **Change in number of self-harm incidents since January 2020**



Source: Institute for Government analysis of MoJ, 'Safety in custody statistics', Table 9a, January 2020–March 2021. Figures exclude Peterborough prison as data does not distinguish between male and female prisoners held on site.

Like violence, self-harm in prisons has risen steeply since 2014 but fell during the pandemic. In 2020/21, there were 52,339 incidents compared to 64,552 in 2019/20 – a fall of 19%. While part of this decline may be attributed to the lower number of prisoners this year, rates of self-harm incidents per 1,000 prisoners still fell by 14.8% over the same period. However, self-harm levels are still higher than they were prior to 2018/19, and 110% above what they were in 2009/10.[48] There were also two more self-inflicted deaths in prisons during the pandemic than the year before.[49]

Although recorded self-harm has fallen, the current statistics do not fully capture the detrimental effect of being locked up for 23 hours a day. An initial stumbling block is that self-harm incidents have to be identified to be recorded, and at some prisons officers have spent less time with prisoners.[50] A Prisons Inspectorate report on Category C men's prisons – low security training and resettlement prisons that house most prisoners in England – noted that "there were no systematic welfare checks in place at Onley or Maidstone to identify any decline in prisoners' mood" during the first lockdown.[51] Other HMIP inspections carried out in August similarly found there were no wellbeing checks being carried out at Erlestoke and Whatton.[52]

The aggregate figures on self-harm also hide a very different picture in men's and women's prisons. After lockdown was introduced, self-harm levels fell in men's prisons, but rose steeply in women's prisons, where the curtailment of family visits and interaction with other prisoners appears to have been felt more acutely. The number of self-harm incidents in women's prisons peaked at 1,138 in August 2020 – 51% above the monthly number in January – before declining, but levels have risen again since February 2021.

Women's prisons already had a higher number of self-harm incidents per inmate than men's. Many women serve sentences far from home, and are more likely to have been primary carers for children before entering the prison system and often experience distress when separated; a higher proportion of women in prison have also suffered past abuse.[53] In 2020/21, there were 3,582 self-harm incidents per 1,000 female prisoners (reflecting 369 prisoners per 1,000 self-harming an average of 9.7 times each) compared to 538 incidents per 1,000 male prisoners (136 prisoners per 1,000 self-harming an average of 4.0 times each).[54]

Prisoners' mental health suffered badly during the pandemic – though improved access to phones and video calling helped over time

Lockdown restrictions have undoubtedly affected prisoners' mental health, with confinement causing anxiety and loneliness.[55] Mental health services were also reduced in many prisons during lockdown. HMIP raised concerns about this in numerous women's and Category C men's prisons during inspections conducted between May and June 2020,[56,57] and a survey conducted between August 2020 and March 2021 found that less than a quarter (22%) of prisoners said it was easy to access a mental health worker.[58]

A Criminal Justice Alliance study also found that many prisoners suffered from lack of family contact,[59] which as noted above was particularly felt in women's prisons.[60] Social visits were cancelled entirely between March and August 2020, before being reintroduced on a restricted basis at some prisons between lockdowns. Prisoners without in-cell phones also had limited access to phone calls, due to reduced time out of cell. MoJ provided prisons with 900 mobile handsets at the start of the pandemic, but this was not enough to meet demand.[61] When lockdown began, some female prisoners were allowed just 10 to 20 minutes of phone time a day.[62]

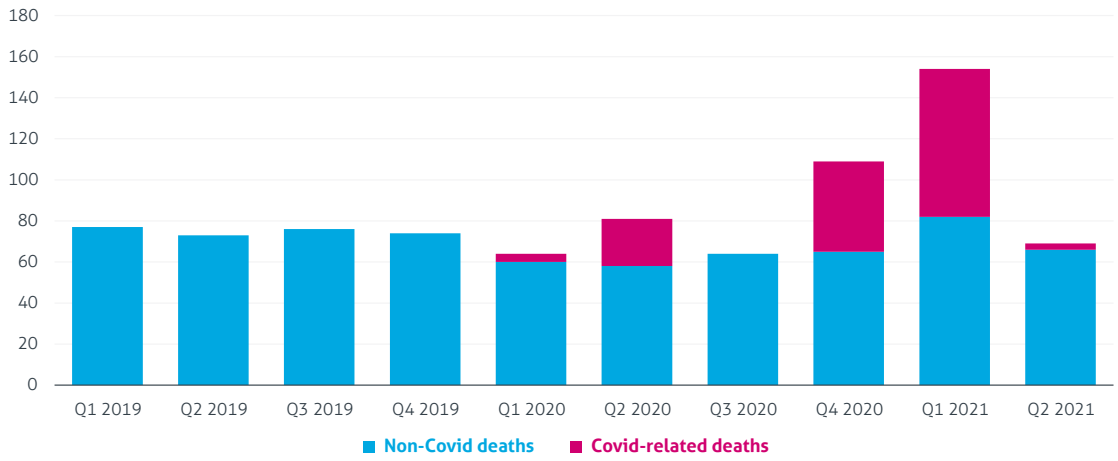
In response to the cancellation of visits, MoJ began to install video-calling facilities in prisons in May 2020 to enable prisoners to contact their families[63] – accelerating plans it had been piloting since 2019 in line with the recommendations of the 2017 Farmer review. By the end of September 2020 the facilities were available in all young offender institutions and women's prisons;[64] this is likely to have contributed to the fall in self-harm in women's prisons from August. In a survey published in January 2021, 97% of prisoners said secure video-calling facilities have helped their mental health.[65] However, some female prisoners noted problems with the technology – such as the software being too sensitive to participants' movement, which interrupts calls and results in the verification process having to take place again, wasting time on short calls.[66]

In-cell phones – another initiative of the Farmer review – have helped some prisoners, but as with the mobile handsets, provision has been an issue: as of April 2021 just 66% of prison cells had these.[67]

Despite such problems, increased access to technology has proved popular. The director general of HMPPS has said that "video calling for prisoners might well be the best thing to come out of Covid in prisons".[68] In-cell telephones are also cheaper for prisoners than the phones on the landings of prisons, and may reduce the pressures prisoners face when using landing phones – such as limited time and privacy.[69] Maintaining access to both after the pandemic has eased, alongside unrestricted in-person visits, could improve prisoner rehabilitation and wellbeing.

Prisons have experienced fewer deaths than expected

Figure 9.6 **Quarterly deaths in prisons**



Source: Institute for Government analysis of HMPPS, 'Covid-19 statistics', Table 1, March 2020–June 2021 and MoJ, 'Safety in custody statistics', Table 5, Q1 2019–Q2 2021.

The purpose of such a restrictive regime was to stop the spread of coronavirus in prisons and, on this count, the prison service has largely succeeded. As of the end of August 2021, 18,301 prisoners had tested positive for Covid and there had been 155 related deaths in prisons.[70] These figures are well below PHE's predictions in March 2020, which estimated as many as 77,800 prisoners could become infected, and 2,700 die from the virus.[71]

How much money would be required to maintain pre-pandemic standards?

Demand for prisons will rise quickly over the next five years, despite the drop in the number of prisoners seen during the pandemic. This is expected to be the result of both the courts resuming normal activity and the extra 20,000 police officers being recruited by the government, both expected to increase charge volumes.

MoJ's latest prison population projections estimate there will be 96,000 people in prison by September 2024 – a 14.5% increase on the population in September 2019. This figure takes into account changes resulting from the extra 23,400 police officers* and policies included in the sentencing white paper[72] (which the government has committed to in the Police, Crime, Sentencing and Courts Bill, which has passed its second reading in the House of Lords), and assumes courts will clear the backlog of cases by the end of March 2024.[73]

However, there is some uncertainty about future prisoner numbers, due to the unknown impact of extra police officers: if charge volumes and/or the case mix differs from current trends, the prison population could be greater or smaller than the central projection. For example, if demand from additional policing is 20% higher, the prison population could rise to 98,300 by September 2024, while if demand is 20% lower, this number could be 93,800.[74] Additionally, the fall in crime during the pandemic could affect prisoner numbers over the next few years but again this is difficult to quantify. There is also uncertainty about the rate at which the courts will be able to clear the backlogs (as discussed in the courts chapter). However, the speed of court recovery will not change how many people enter prison, in total, over the next five years, only at what point they enter. If courts recover quickly, there will be a spike in the prison population in the short term, but a slightly lower population over the longer term.

If costs per prisoner remain the same as in 2019/20, the government will need to spend 14.5% more in real terms in 2024/25 than in 2019/20 to meet the central scenario and maintain service provision at current standards. This is greater than government spending has risen over the past five years (at 9.9% between 2014/15 and 2019/20).

If, however, the government wanted to spend more to improve the quality of prisons – for example, expanding access to rehabilitative activities, improving security or increasing the number of officers per prisoner – or has to increase staff pay above economy-wide inflation to retain officers, then it will of course have to spend more. Addressing the mental health needs of prisoners, which have grown during lockdown, may also increase cost pressures. It is difficult to quantify how much this will cost as the data on the number of people in prison with mental health problems, and how much the government is spending to address this, is poor – but it is almost certain there will be increased need for mental health care provision in the next few years.[75]

* This figure also includes those additional police officers already recruited through precept funding.

In addition to higher running costs, a large proportion of which is staff, the government will also have to make a one-off capital investment to accommodate the higher number of prisoners projected. There are currently not enough prison places to hold the projected number of prisoners. The total useable operational capacity across England and Wales was just 80,641 at the end of August 2021.[76] The government's plans to deliver 18,000 new places by the mid-2020s,[77] at a cost of £4bn, will be enough to meet the projected population of 96,000 by 2025 – if delivered. Based on the performance of the government's previous prison-building programme announced in 2015 – of which just 206 of a promised 10,000 places were built on time* – this will be difficult to do.[78]

How much would it cost to address the legacy of the pandemic in prisons

Prisons undoubtedly faced disruption during the pandemic: regimes were altered due to social distancing, purposeful activity decreased, and fewer prisoners entered prisons. However, unlike other public services, this has not created clear backlogs. Most prisoners are not required to 'catch up' on purposeful activity to successfully complete their sentences and the main disruption to the number of people entering prisons occurred as a result of fewer cases heard in the courts, where there is a large backlog, rather than factors in prisons themselves. The cost of this backlog is already reflected in higher demand over the coming years.

* In addition to the missed target, the opening of the prisons under construction at Wellingborough and Glen Parva has been pushed back. Grierson J, 'Government reveals second new prison in England to be privately run', *The Guardian*, 6 November 2018, retrieved 22 September 2021 www.theguardian.com/society/2018/nov/06/prison-england-private-hmp-glen-parva-leicestershire-wellingborough and 'Glen Parva prison: Cost climbs by £116m', BBC News, 2 September 2020, retrieved 22 September 2021, www.bbc.co.uk/news/uk-england-leicestershire-53999384

Methodology

For the nine services we cover in this report, we project how much money the public sector would have to spend in order to maintain pre-pandemic standards. For general practice, hospitals, children's social care, schools, and criminal courts – where there is enough data to quantify backlogs – we estimate how much it would cost to address the legacy of the pandemic.

To estimate the cost of maintaining pre-pandemic standards, we project growth in underlying demand for each service until 2024/25, the final year of the upcoming spending review. In our projections, we assume that the cost of providing each service will increase in line with the rate of economy-wide inflation, and do not make any assumptions about the scope for efficiency. We discuss whether there are good reasons to think that demand or cost pressures will rise faster or slower than our projections, and whether there is scope for greater efficiency, in each chapter.

For police and neighbourhood services, our central scenario is that underlying demand will rise in line with England's population growth[1] in the absence of better measure. For prisons we assume that underlying demand – the number of prisoners – rises in line with MoJ prison population projections.[2] As our projection for neighbourhood services is solely based on England population growth, and we do not model a backlog in neighbourhood services, we do not discuss here.

The following methodology describes how we project underlying demand for GPs, hospitals, adult social care, children's social care, schools, police, criminal courts, and prisons and how we project backlogs in hospitals, general practice, children's social care, schools, and criminal courts.

1. General practice

Demand (Figure 1.2)

Our demand projections use the NHS's weighted capitation formula, which assigns a relative value for the demand created by individuals based on their age and gender. We joined this data with population projections from ONS to form our forecast. We note that, could rise faster, and that the Health Foundation has estimated that primary care activity would have to rise 1.4% per year between now and 2024/25 in order to meet underlying demand pressures.[3]

Backlogs

The NHS changed how it collected 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, however granular daily counts of appointments are only available from December 2018. There is, however, a consistent time series off the number of referrals made by GPs is available back to 2008.

We use the referrals time series to estimate the historical number of appointments with GPs, and total appointments in primary care. Our key assumptions were the long-term trend in the ratio of GP referrals to appointments. While some appointments

will generate more than one referral we assume that this is a small enough fraction to be ignored. We also assume that the long-term trend is one of falling referral rates, reflecting successive governments' policies to divert patients away from specialist care where possible. We also assume that GP appointments as a share of all appointments in primary care have also been falling over time, reflecting successive governments' policies to allow other members of staff in general practice to perform more primary care functions – such as pharmacists and nurse practitioners.

For our backlog projections we project the trend in appointments since October 2018 to estimate the number of appointments and referrals which would have occurred in the absence of the pandemic. For our long-term projections we used the reconstructed appointments series and our models of seasonality and underlying demand to project the number of appointments needed to meet demand over the next five years.

To project the government's manifesto commitment we assumed that 10 million additional appointments would be delivered in 2022, 20 million in 2023 and so on up to 50 million additional per year – although providing these appointments depends on an recruiting and retaining 6000 net additional GPs.

To project the number of appointments needed to meet the backlog demand we assume that the missed referrals could be spread over three years. Our estimate of the number of missed referrals is 6 million and we spread this out as 3 million in the first year, 2 million in the second and 1 million in the third. The time it takes to clear the backlog will depend, among other factors, on how many patients return, so in our analysis we present three scenarios: one where 100% of missed referrals need to be addressed (the central line); one for 75%, where some cases have either resolved themselves, or have already been referred via another route, such as emergency admissions (the lower bound); and one for 125%, where the effects of the pandemic have caused increased incidence of diseases, such as mental health conditions (the upper bound).

The number of appointments needed to cover these referrals also depends on the rate at which doctors refer patients. Prior to the pandemic the average ratio of referrals to appointments with a GP was ~9.4%. Since the first lockdown this has been ~7.4% on average, as GPs were told not to overwhelm hospital capacity. In our projections we assumed that from January 2022 GPs return to referring patients at the pre-pandemic rate, although referrals rates may stay lower than that if hospital capacity is constrained.

2. Hospitals

Staff absences (Figure 2.3)

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. However 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, however for the sake of simplicity we disregarded this.

In all cases we calculated the number of FTE days lost to sickness in a given month for each category as a share of the total FTE days available, and presented this percentage as the sickness absence rate.

Demand (Figure 2.5)

Our demand projections use the NHS's weighted capitation formula, which assigns a relative value for the demand created by individuals based on their age and gender. We joined this data with population projections from ONS to form our forecast.
This could rise faster. The Health Foundation has estimated that acute care activity (outpatients, A&E, non-elective, and elective operations) would have to rise 2.1% per year between now and 2024/25 in order to meet underlying demand pressures.[4]

Relative hospital activity (Figures 2.7, 2.11, and 2.12)

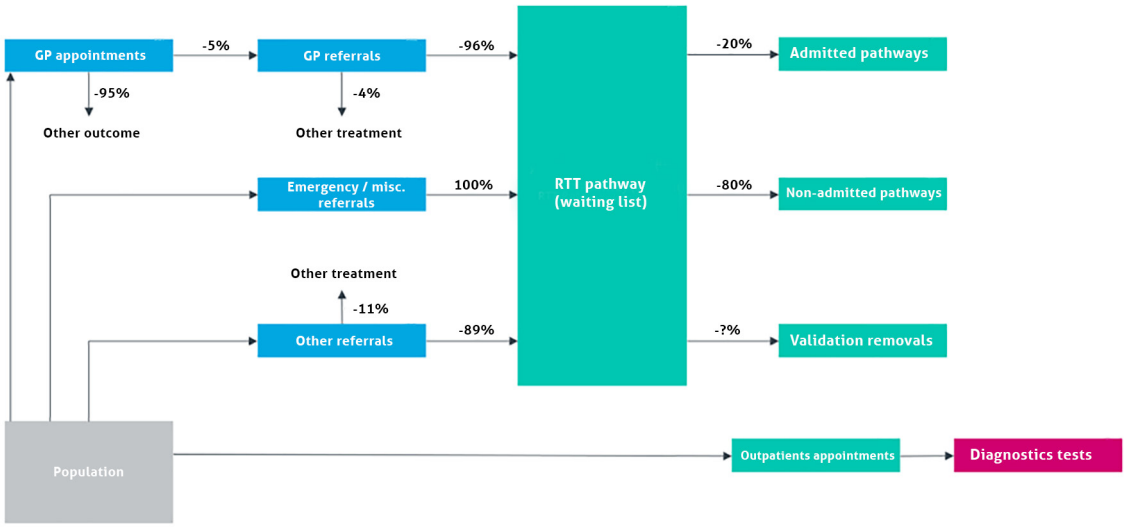
To assess the current levels of activity within hospitals – for both treatment pathways and diagnostics – we compared the actual activity levels to a projection based on pre-pandemic trends since 2015. The ratio of actual to expected activity is presented in this chapter.

IfG health system model

To model backlogs, we use a version of an stock and flow model that describes how patients flow through the primary care and hospital systems, ultimately receiving care. This model does not capture the entire scope of activities that hospitals undertake, but it does reflect key areas of work.

Most of the parameters within the model were taken directly from data provided by NHS Digital or NHS England.

Model of **patient flows through the primary and acute care systems**



Within this model we define a range of key parameters:

- GP Appointments: To define this we use the same data on the number of appointments in primary care monthly as used in chapter 1 of this report. We estimate the rate at which GPs refer patients (per appointment) from this data.

- GP Referrals: To define this we use the same data on the number of appointments in primary care monthly as used in chapter 1 of this report. The share of patients who receive a referral to specific acute care is determined from NHS England's Monthly Referrals Return (MRR) time series.

- Emergency/Misc Referrals and Other Referrals: We estimate these based on the number of new RTT pathways each month, and the number of GP referrals.

- RTT Pathways: The size of the RTT wait list is published by NHS England.

- Admitted and Non-Admitted Pathways: NHS England publishes detailed monthly information of the number of patients on pathways.

- Validation Removals: Due to the way hospitals record and report treatment pathways there are month-to month discrepancies in the totals. These can occur when a patient is transferred between hospitals, or moves from one place to another. Validation removals can be calculated using the following relationship.

$$W_n = W_{n-1} + RTT_n - A_n - NA_n - V_n$$

  The size of the RTT waiting list in each month (Wn) is the sum of the size of the waiting list at the end of the previous month (Wn-1), the number of new RTT periods (RTTn), minus the number of patients beginning admitted (An) or non-admitted (NAn) treatment pathways, minus the number of validation removals (Vn)

In the chapter, we estimate the cost of keeping waiting lists at pre-pandemic growth rates would be £7bn per year for the next five years. To calculate this, we model a 10% increase in non-admitted and admitted pathways to eliminate the backlog over a five year period , and costed the 10% increase in pathways as a 10% increase in NHS providers acute and specialist income in 2018/19.[5]

3. Adult social care

In order to project demand, we break down adult social care spending into seven categories, based on the 2019/20 NHS Digital *Adult Social Care Activity and Finance Report*.[6] We make the following assumptions about rates of growth for each of these seven service areas:

Service category	Gross spending 2019/20 (£bn)	Growth rate assumption	Projected growth between 2019/20 and 2024/25
People aged 65 and over receiving a long-term community care package	2.7	Number of users increases in line with London School of Economics Care Policy and Evaluation Centre (CPEC) projections for publicly funded community care for older service users	9.7%
People aged 65 and over receiving a nursing, residential or supported accommodation package	5.1	Number of users increases in line with CPEC projections for publicly funded residential care for older service users	6.7%
Working-age adults receiving care for learning disability support	5.4	Number of users increases in line with CPEC projections for publicly funded care for learning disability working-age service users	8.6%
Working-age adults receiving care for physical and sensory support	1.5	Number of users increases in line with CPEC projections for publicly funded physical support for working-age users	4.2%
People aged 65 and over receiving a short-term care package	0.5	Number of users increases in line with CPEC projections for publicly funded community and residential care for older service users	7.4%
Working-age adults receiving care for mental health support	0.8	Number of users increases in line with CPEC projections for publicly funded mental health support for working-age users	2.6%

Working-age adults receiving care for memory and cognition support	0.1	Number of users increases in line with CPEC projections for all publicly funded support for working-age users	6.06%
Other expenditure	3.7	Spending rises in line with the average increase in the seven other categories	7.43%

Our central demand projection ("excluding cost pressures") implicitly assumes that the cost of providing adult social care rises in line with economy-wide inflation. These figures may well underestimate future growth in the cost of providing adult social care because they do not account for the government's planned above-inflation increases in the national living wage.

Local authorities have so far paid more to implement the national living wage in adult social care. Following its introduction in April 2016,[7] the prices that local authorities paid for privately provided home care, residential care and nursing care all rose faster than economy-wide inflation.[8] Local authority directors of adult social care report that they plan to spend an additional £494m to implement national living wage increases this year (2021/22).[9]

Adult social care is the only public service covered in this report where the government has set out pay plans for most of the workforce up to 2023/24. For this reason, and given the difference that including rising unit costs makes to our projection, we also present a projection including the increase in the cost of care ("including cost pressures").

4. Children's social care

To estimate spending on children's social care in 2020/21, we assume all the reported Covid spending on children's social care was additional. We calculate the change in budgeted local authority spending on children's social care in 2019/20 and 2020/21,[10] including additional Covid-19 spending in 2020/21.[11] We multiply the change to the Department for Education's figure for children's social care spending in 2019/20[12] to estimate spending in 2020/21. DfE publishes local authority children's social care spending data and the final 2020/21 statistics are due to be published in December 2021.[13]

To project demand, we break down children's social care spending into three 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 following assumptions about rates of growth:

Service category	Gross spending 2019/20	Growth rate assumption	Projected growth between 2019/20 and 2024/25
Foster placement	£1.8bn	Increases in line with the growth in the rate of foster placements per child between 2007/08 and 2019/20	10.4%
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	16.0%
Other expenditure	£5.8bn	Increases in line with the rate of episodes of need per child in England between 2012/13 and 2019/20	-0.1%

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.

To estimate the number of missing referrals as a result of pandemic pressures, we:

- Calculated the distribution of how long children-in-need and looked-after children stay in care using the latest pre-pandemic data available for 2019/20[14]
- Assumed that the rate of referrals returns to normal in the third quarter of 2021, from July 2021
- Assumed that exits during the pandemic fell at the same rate as entry from lower referrals
- Calculated how many additional children will become children-in-need and looked-after children over the next few years by assuming that 6.7% of referrals return in 2021/22 in the central scenario, and a further 6.7% of referrals return in 2022/23 in the high scenario
- Calculated how much it would cost local authorities to support these children by assuming that spending on foster and residential placements (37% of children's social care spending) would have to rise in line with the increase in the number of looked-after children and assuming that spending on all other aspects of children's social care would have to rise in line with the increase in the number of children-in-need (63% of children's social care spending).

In the modelling, we assume that children who are referred to local authorities after the pandemic spend as much time receiving services as they would have if they were referred during the pandemic – which, as described above – is conservative and may underestimate both the number of children who return, and how much support they might require.

6. Schools

To project how much schools would have to spend to maintain pre-pandemic standards, 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 Department for Education projects that the number of primary school pupils will fall over the next five years while the number of secondary school pupils will increase.

To calculate the spending required to maintain the scope and quality of state school education as it was in 2019/20, 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.

Service category	Gross funding 2019/20	Growth rate assumption	Projected growth between 2019/20 and 2024/25
Primary schools	£19.8 bn	Number of pupils grows in line with DfE projections for the numbers of primary school children	-5.1%
Secondary schools	£18.5 bn	Number of pupils grows in line with DfE projections for the numbers of secondary school children	7.4%

As described in the demand section above, this probably underestimates the true cost pressures that schools face because of likely rises in staff costs. This projection also assumes that the only factor that will affect demands on schools over the next few years is a change in the number of pupils. This may further understate spending pressures. In reality, spending pressures on schools may rise faster than numbers of pupils, given the growing number of pupils who receive additional support for special educational needs.[15] The cost to provide support to pupils with SEN was rising before the pandemic[16] and may increase afterwards, especially as fewer assessments took place during the pandemic. If the share of pupils receiving support for SEN continues to rise, then mainstream schools may have to spend more than we project to maintain the same standards of education.

7. Police

In order to project demands on the police, we break their responsibilities down into four components:

- public demand relating to crimes (such as robbery, fraud or weapons offences)
- public demand that does not relate to crime (mental health incidents or anti-social behaviour, among others)
- protective demand (including prevention, intelligence-gathering or safeguarding through co-operation with other agencies)
- internal demands on police time, such as administrative tasks.

This distinction between different components of demand is based on recent analysis by the College of Policing,[17] the National Police Chief's Council,[18] and Crest.[19] To calculate overall demand for the police, we weighed these different elements based on the estimated volume of incidents and cost of incidents to the police (this is detailed in the table overleaf).

We then assume that internal demand would not increase. We assume that all non-crime demand on the police would grow in line with the population of England and Wales. We also assume that most crime demand would grow in line with the population. For this, we use the ONS' Principal projections for England and Wales.[20]

To illustrate an alternative scenario, we project what would happen if certain crimes rise at a faster rate than population growth based on past trends and future priorities – namely rape and fraud – and what would happen if they grew at twice the rate of population growth. Although some of these crimes have risen at an even faster rate in recent years, we make a more conservative estimate because part of the increase in recent years is due to better reporting rather than crimes committed. We then weighted future crime demand relevant to the proportion of spending these crimes account for.

In this scenario, future demand will increase by 3% between 2019/20 and 2024/25. Our assumptions for the costs and rate of growth for each category of demand are detailed below.

Overall category	Types of demand	Estimated volume of incidents (based on CREST 2018)	Average cost per incident (£)	% of total demand	Cost assumptions	Projected growth between 2019/20 and 2024/25	Growth rate assumptions
Public demand: crime (where Home Office data is available)	Homicide, violent crime, sexual offences, robbery, theft, arson, criminal damage	12.4%	1,719	42.5%	We have derived the average weighted cost per crime (£, in 2015/16 prices) using Home Office cost data.	2.3%	We have assumed that most crime demand will grow at the same rate as the population in England and Wales.
	Rape and fraud	3.5%	4,560	32.4%		4.6%	We have assumed that rape and fraud will grow at twice the rate of the population in England and Wales.
Public demand: crime (where Home Office data is not available)	Drug offences, possession of weapons, unlawful driving, stalking and harassment, bicycle theft, shoplifting, public order offences	10.2%	324	6.6%	We have assumed costs for each crime based on crimes for which cost data is available.	2.3%	We have assumed that most crime demand will grow at the same rate as the population in England and Wales.
Public demand: non-crime	Mental health, missing persons, drugs, alcohol, domestic abuse, anti-social behaviour and traffic incidents	38.8%	125	9.7%	We have attributed the same weight/ costs to non-crime, protective and internal demand. Although police response to more non-crime related incidents, we assumed these activities are less costly for the police to undertake than responding to crime.	2.3%	We have assumed that non-crime demand will grow at the same rate as the population in England and Wales.
Protective demand	Safeguarding work	22.5%	125	5.6%		2.3%	
Internal demand	Internal demand	12.5%	125	3.1%		0.0%	We have assumed that internal/ administrative demand will not increase.

8. Criminal courts

Demand

We project demand separately for the crown and magistrates' courts.

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 'triable either way' cases, 'indictable only' cases, appeals from the magistrates' courts and sentencing decisions from the magistrates' courts.[21] We assume that: (i) longer hearing times are a result of cases being more complex, rather than because the court is operating inefficiently; and (ii) the cases received would have had similar hearing times to the ones disposed of, within case-type (triable either way, indictable only, appeals and sentencing), 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 in each year.[22] We assume that magistrates' court demand and crown court demand evolved in the same way between 2010/11 and 2012/13 (magistrates' data is available only from 2012/13).

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.[23] Second, we use the average cost per sitting day in the crown court and magistrates' courts, which the National Audit Office reported in 2016.[24] This implies that 61% of court demand comes from the crown court and around 39% from the magistrates' courts. We then project demand forward separately for the crown and magistrates' courts.

Impact of 20,000 police officers

We model three scenarios for the impact of 20,000 additional police officers on the criminal justice system, assuming that the number of officers grows by 8,000 in 2021/22 and 6,000 in 2022/23.

- '**Low**' – charges per officer continues to decline at the same average annual rate that it has since 2010 (3.4% per year)
- '**Central**' – charges per officer stays constant from 2019/20 onwards
- '**High**' – charges per officer increases at the same average annual rate that it has declined since 2010 (i.e. it increases by 3.4% per year).

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. This means that 74%

of 2019/20 magistrates' cases are unaffected by the subsequent increase in charges, while 26% are and increase in line with charges. All cases in the crown court are affected.

Service category	Share of demand in 2019/20	Historic growth rate	Growth rate assumption
Crown court: triable either way	22.5%	-14.6% since 2010/11	Increase in line with police charges
Crown court: indictable only	32.8%	-13.5% since 2010/11	Increase in line with police charges
Crown court: sentencing from magistrates'	3.9%	+21.1% since 2010/11	Increase in line with police charges
Crown court: appeal from magistrates'	1.5%	-32.1% since 2010/11	Increase in line with magistrates' cases
Magistrates' courts: summary offences	29.6%	+2.7% since 2012/13	Unchanged going forwards
Magistrates' courts: other	11.9%	-24.7% since 2012/13	Increase in line with police charges

Backlogs

The actual number of backlogs is given by HMCTS weekly statistics up to the end of May 2021. 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 that end up as jury trials are the same as pre-Covid. The 'missing' cases is then the gap between those assumed to be entering the courts system and those that are completed each week.

- 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].

To calculate how much more spending will be needed to eliminate the backlog, we calculate the increase in the backlog as a share of cases processed in 2019/20 (44%) and assume it will cost 44% of the 2019/20 budget to clear the remaining cases. We also assume that extra spending translates into additional sitting days at a 1:1 rate, so a 10% increase in spending translates into a 10% increase in sitting days. We further assume that 2015/16 sitting days represent the 'maximum' that the courts can process given the current court estate and size of judiciary.

9. Prisons

To project demand for prisons, we use the Ministry of Justice's central estimate for prisoner numbers over the next five years, which was published in November 2020.[25] The MOJ's own modelling is simpler than that used in past years. Constraints on court capacity, due to social distancing, are reflected in this model over the period of restrictions.

The MoJs central estimate is that the prisoner population will rise by 14.5% between 2019/20 and 2024/25. This projection incorporates the recruitment of the additional 20,000 police officers and the estimated impact of policies included in the Sentencing White Paper – including the provisions for increasing the release point for violent and sexual offenders sentenced to a standard determinate sentence of 4-7 years; the Statutory Instrument to increase custodial sentences for serious offenders with a custodial sentence of 7 years or more; the Domestic Abuse Bill 2020; the Serious Crime Act 2015; and the Offensive Weapons Act 2019. It does not, however, estimate the impact of future Government policies that have not received Royal Assent in Parliament, such as the Police, Crime, Sentencing and Courts Bill, introduced in March 2021.

The estimate also assumes that social distancing restrictions ease at the end of May 2021, and court workload then returns to levels seen in the six months prior to the pandemic, so that the courts gradually clear the backlog of cases that has built up by the end of March 2024. This means the MoJ projections for 2021 are higher than the current prison population, as restrictions were eased two months later, but this should not impact the five year projection.

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